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# ROYAL COMMISSION ON HEALTH SERVICES

## HEARINGS

HELD AT

**TORONTO**

**ONT.**

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V. 48 Briefs 242-246  
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VOLUME #8

E R R A T A

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DR. FRANK J. RO

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E R R A T U M  
(Volume #47 - 7.5.62)

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TORONTO, ONTARIO

ROYAL COMMISSION ON HEALTH SERVICES

Proceedings of the hearings  
held in Toronto, Ontario,  
on the 8th day of May, 1962.

COMMISSIONER MEMBERS:

Chief Justice EMMETT M. HALL --- Chairman

MISS ALICE GIRARD, R.N.

DR. C. L. STRACHAN

DR. ARTHUR F. VAN WART

MR. M. WALLACE McCUTCHEON, Q.C.

PROF. O. J. FIRESTONE

DR. DAVID M. BALTZAN

COMMISSIONER COUNSEL:

MR. R. N. HALL, Q.C.

MEDICAL COUNSEL:

DR. PIERRE JOBIN

DIRECTOR OF RESEARCH:

PROF. BERNARD BLISHEN

COMMISSIONER SECRETARY:

MR. N. LAFRANCE





ANNUAL REPORT OF THE

FOREST SERVICE

FOR THE YEAR 1911

PRESENTED TO THE CONGRESS

BY THE COMMISSIONER OF THE FOREST SERVICE

JOHN M. WATSON, COMMISSIONER

WASHINGTON, D. C.

1912

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---On resuming at 9:30 a.m.

THE SECRETARY: Mr. Chairman, I have here before we begin with today's presentations a letter from the Catholic Family Service of Medicine Hat and Redcliff dated April 16th in which they endorse the brief submitted by the Edmonton Family Service Bureau which I would like to read into the record.

Chief Justice Emmett Hall, Chairman,  
Royal Commission on Health Services,  
Court House,  
Regina, Saskatchewan.

Dear Judge Hall:

The Board of Directors of Catholic Family Services of Medicine Hat has had an opportunity to study the Brief submitted to the Royal Commission on Health Services by the Edmonton Family Service Bureau.

We are a private family service agency operating under the authority of Catholic Charities of the Diocese of Calgary and have as our main purpose the strengthening and preservation of family life. As part of our service we offer a Homemakers Service similar to that offered by the Edmonton Family Service Bureau.

We wish to endorse the principle contained in the aforementioned brief that Federal grants be made available through the federal-municipal-grant structure to permit municipalities to issue suitable grants through non-government organizations by charging back against a Municipal-Provincial-Federal health grant structure. We feel that in any health plan, the







care of the family during a mother's illness and convalescence is an important part of the total health plan.

Sincerely,

(Mrs.) Louise Desharnais,  
Secretary.

Sir, today the first presentation is from the Physicians' Services Incorporated and Dr. Lockhart will address the Commission. Their submission will be known as Exhibit 242 and their Annual Report as 242A.

---EXHIBIT NO. 242:

Submission of Physicians' Services Incorporated.

---EXHIBIT NO. 242A:

Annual Report of Physicians' Services Incorporated.







SUBMISSION OF  
PHYSICIANS SERVICES INCORPORATED

APPEARANCES: Dr. J. O. Lockhart  
Mr. W. S. Major

THE CHAIRMAN: Dr. Lockhart you may remain seated if you prefer.

DR. LOCKHART: I am Dr. J. O. Lockhart, a general physician from Hamilton, Ontario, President of Physicians' Services Incorporated. On behalf of the Corporation, we extend greetings to the Commission and we will be pleased to help your deliberations in any way we can.

With me, is Mr. W. S. Major, General Manager of P.S.I. to whom I expect you will direct most of your questions regarding the operation of the Corporation.

Physicians' Services Incorporated, better known by its registered initials P.S.I. is a physician-sponsored plan underwritten by the physicians of Ontario under the aegis of the Ontario Medical Association.

The submission presented to you is interested primarily in showing what P.S.I has done in the area of prepaid physicians' services.

We used statistical tables to achieve this objective and kept narrative to a minimum.

We trust the submission will be of some help to you and we are prepared to answer, to the best of our ability, any questions which you may have



10-10-41

Dear Mr. [Name]

I am writing you in response to your letter of 10-10-41.

I am sorry that I cannot give you a more definite answer at this time. I am sure that you will understand my position. I am sure that you will understand my position. I am sure that you will understand my position.

Sincerely,

W. H. [Name]

I am sure that you will understand my position. I am sure that you will understand my position. I am sure that you will understand my position.

Very truly,

W. H. [Name]

I am sure that you will understand my position. I am sure that you will understand my position. I am sure that you will understand my position.

I am sure that you will understand my position.

I am sure that you will understand my position. I am sure that you will understand my position. I am sure that you will understand my position.

I am sure that you will understand my position.

I am sure that you will understand my position.

I am sure that you will understand my position.

I am sure that you will understand my position. I am sure that you will understand my position. I am sure that you will understand my position.



Lockhart

9004

relative to that submission.

THE CHAIRMAN: How do you propose to proceed, Dr. Lockhart? Were you going to deal with your summary and recommendations?

DR. LOCKHART: I would suggest we could leave that entirely up to whatever you wish.

THE CHAIRMAN: We are here to listen. I think it would be desirable if you would open up with any recommendations that you may have, that you wish to make.

DR. LOCKHART: The recommendations as listed on page 1 of our brief are very short ones:

1. The voluntary method of the prepayment of physicians' services should be maintained and allowed to grow freely with active competition between the providers of these services.
2. The citizen and industry should be allowed to make arrangements for prepaid physicians' services satisfactory to those involved and with the consideration to local or district conditions.

Those are, in the main, our two recommendations.

THE CHAIRMAN: I may make an observation, Dr. Lockhart, we are naturally interested in what P.S.I. has done. Our mission is to investigate, not the past, but the future, what may be acceptable and right now for the Federal Government and the Provincial Government in co-operation to achieve the best possible health services for all Canadians. While we are interested, as I say, in what has been accomplished we







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4 are also interested in what P.S.I. sees for itself as  
5 a part of the future. Have you any observations to make  
6 in that context? Do you think you should pass out of  
7 business or continue or what?

8 DR. LOCKHART: I think in the presenta-  
9 tion of this brief we felt the development in the past  
10 and the rapid growth of P.S.I. was in itself an  
11 indication of how P.S.I. can fit into the future if  
12 its continuous rapid expansion of the past fourteen  
13 years were continued. We feel that it definitely has  
14 a role in any future development.

15 THE CHAIRMAN: What role?

16 DR. LOCKHART: The role of continuing  
17 to provide prepaid medical coverage; the role of  
18 continuing to co-operate with organized medicine in  
19 making this prepaid coverage available; the extension  
20 of our prepaid coverages to as many segments of the  
21 population as we can; the recognition there are certain  
22 areas in prepaid coverage that have limitations as far  
23 as private plans are concerned and in association with  
24 our parent, the Ontario Medical Association in studying  
25 methods for expansion in the future.

26 THE CHAIRMAN: I think you have  
27 probably dealt with one of the most important aspects  
28 there in the matter that there are limitations to what  
29 prepaid coverage may be able to do, certainly has been  
30 able to do in the past. What do you see developing in  
terms of voluntary prepaid coverage in P.S.I., coverage  
for all, young and old, rich and poor, those with chronic  
disabilities and the mentally ill, everybody? Do you







Lockhart

9006

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4 see the voluntary doctors-sponsored group being able to  
5 come up with a program that would cover everyone.

6 DR. LOCKHART: I see no reason why  
7 a doctor-sponsored plan couldn't come up with a program  
8 available to everybody.

9 THE CHAIRMAN: Would you accept my  
10 proposition, that would cover everyone, and not merely  
11 be available?

12 DR. LOCKHART: Yes, I think we could.  
13 It could cover everyone. The limitations as far as we  
14 would be concerned at the moment do not include the  
15 so-called uninsurables because our present plan does  
16 include the so-called uninsurables without question.

17 THE CHAIRMAN: You say it does?

18 DR. LOCKHART: It does in the groups  
19 we are able to cover. There are no exclusions for any  
20 pre-existing medical condition, chronic illness or that  
21 type of thing.

22 THE CHAIRMAN: That is in your groups.  
23 What about individuals?

24 DR. LOCKHART: In individual plans  
25 it is a limited plan to provide limited care in hospital  
26 only, and again there are no limitations for pre-existing  
27 conditions. The only limitation is on the age limit  
28 to get into the plan of 65. Once an individual is in  
29 the plan they can carry on as long as they wish.

30 THE CHAIRMAN: Speaking for myself and  
being very close to that limit you mentioned, sir, now  
what is there in prospect for those of us in that 65  
area, as individuals?





Lockhart

9007

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4 DR. LOCKHART: I would suggest that,  
5 on experimentation in the individual plan we set an  
6 age limit of 50, and over the course of time with  
7 experience we decided we could increase the age to 60.  
8 After a further period of experience we increased the  
9 age to 65--to 64. The future may well depend upon our  
experience in the course of time.

10 THE CHAIRMAN: But, Dr. Lockhart, and  
11 I don't want to be argumentative or critical. That is  
12 not our purpose at all. But we are concerned with seeking  
13 opinions on the whole field now. It would appear for  
14 the moment so far as your voluntary doctor-sponsored  
15 plan, there is no place for the over 65 who hasn't  
16 previously insured himself?  
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Dr. L. B. ...

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Lockhart

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DR. LOCKHART: At the present moment that unfortunately is true.

THE CHAIRMAN: Is that the limitation? Is that a limitation that we must accept in the development of the doctor-sponsored plan, or is there an avenue open there?

DR. LOCKHART: I think there is definitely an avenue open, where, with the development and the economic situation finding itself, there is no reason why these plans cannot expand to increase their coverage.

THE CHAIRMAN: What do you mean by the "economic situation"?

DR. LOCKHART: As the plans increase in scope so we find that we have been able to increase the breadth of coverage.

THE CHAIRMAN: How long are the sixty-fivers going to have to wait?

MR. MAJOR: Mr. Chairman, in the statistical trend lines it is very difficult to extend this and say that we now have individual statistical background to prove if we open this coverage up to the over age 65, everything else being compatible with the terms of our agreements, that we could do this at any particular time. By that I do not mean to say it would take 50 years, but I am not too sure.

THE CHAIRMAN: Even the major part of that would eliminate a great many of them?

MR. MAJOR: That is correct. Time will eliminate them from coverage, from the need for coverage, because we are expanding this as we grow. I would think







Major

9009

that in three years time there will be enough statistical evidence from an economic standpoint to expand the coverage of P.S.I. to every citizen, regardless of age or condition.

This is a considered guess, Mr. Chairman. I think we could extend lines statistically and come reasonably close to proving this, and, after all, we are not too sure what the economic situation over the whole country will be and what drastic circumstances would arise to delay things or hurry them.

THE CHAIRMAN: I suppose if we wait for certainty, we would still be waiting for Columbus to find America. You don't accept what the situation is going to be 10 or 15 or 3 years from now as being valid in terms of experimentation, do you? Just to clarify, your present plan is being offered to the individual. That is somebody not in a group. An in-hospital plan. You are not offering a general coverage home and office care?

DR. LOCKHART: At the present moment we are not. We have set it but it has not been made available, as yet.

THE CHAIRMAN: Have you given consideration to a pilot project that would be an all-inclusive coverage?

DR. LOCKHART: Yes, we have in our community enrolment.

THE CHAIRMAN: Let's speak of individuals.

DR. LOCKHART: This is an individual plan in our community enrolment. It's essentially an individual plan; provides the same coverage completely as our Blue





Lockhart

9010

group plan but on an individual basis in communities.

THE CHAIRMAN: What percentage of the community?

DR. LOCKHART: We have aimed at a percentage but we have not set it at a definite figure at all. For instance, in our brief you will see that - I think it's in one community we have 54% and another over 60.

THE CHAIRMAN: That is, I take it, in the rural areas?

DR. LOCKHART: We have three communities. One of about 1,000 people. One of about 4,500 and one of 10,000 people that we are experimenting - this is an experimental group or experimental method of individual coverage on a community basis.

THE CHAIRMAN: That type of thing could not be offered, or could it, to a metropolitan area?

DR. LOCKHART: Well, as I said, this is, from our point of view, an experimental area in this province. We are delving into something that had not been done before. We did not know the implications.

THE CHAIRMAN: When did you begin it, Dr. Lockhart?

DR. LOCKHART: Just a year ago.

THE CHAIRMAN: You say it has not been done before?

DR. LOCKHART: In this province.

THE CHAIRMAN: In this province, yes, because I take it you will be aware of the experiment with the H.I.P. in New York?





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THE CHAIRMAN: ...  
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THE CHAIRMAN: ...

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with the ...



Lockhart

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DR. LOCKHART: Yes.

THE CHAIRMAN: In which they have taken in the over-75's, everybody, on the pilot project. Now, when you speak of it being impractical in terms of your experience to take in the over-64's, as individuals, you mean with your present premium structure?

DR. LOCKHART: Yes.

THE CHAIRMAN: And in the sections where you do take in up to 64, is that at the same premium as at the other age levels or is that at a higher premium? Is there a graduated premium?

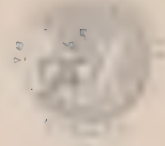
DR. LOCKHART: No, it's the same premium.

THE CHAIRMAN: Have you been able to determine at all what the increase in premium might be to cover those over 75, acknowledging that the over-75 and over 65 require more medical attention per capita than those younger?

MR. MAJOR: No sir. We have not been able to determine that. There is not enough statistical evidence yet from this pilot mill to give us a green light to expand this. It will take, as statistics go in medical care, from two to three years to be positive of what approach you should take.

THE CHAIRMAN: Are you saying, in effect, private enterprise cannot find a way of handling this situation to provide the coverage for the over-64's?

MR. MAJOR: No, I am not saying that, Mr. Chairman. I am saying that making things reasonably compatible, putting the proposition in perspective, there is a limit, a reasonable limit, to what you can ask a



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Major

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citizen to pay on a prepaid principle basis, and we don't know, or we have no idea, what that reasonable limit is and I doubt if anybody really has this kind of statistic available, even H.I.P.

We think that private enterprise, proceeding as it has done in the past with prudence, will eventually find the best answer.

THE CHAIRMAN: I am sorry, I was putting a question to Dr. Baltzan about the Kaiser Permanente plan in California as to the experimentation they had done along these lines. Are you aware of it at all?

MR. MAJOR: Slightly.

THE CHAIRMAN: I know it's in your tabulation but for discussion purposes now what is the premium for a family; I am talking on an individual basis, say, two children, father and mother, two children or three children, whichever one?

MR. MAJOR: In our comprehensive, sir, it's \$30 a quarter.

THE CHAIRMAN: \$120 a year?

MR. MAJOR: Yes, that is correct.

THE CHAIRMAN: What coverage does that give?

MR. MAJOR: All the services usually performed by a licensed medical practitioner.

THE CHAIRMAN: In the hospitals?

MR. MAJOR: No, across the board.

THE CHAIRMAN: That is for the individual?

MR. MAJOR: That is the Blue plan. No, that is not a group plan - I am sorry - the individual





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Major

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plan, or what we call the non-group plan, it is in hospital,  
and to keep the record straight, sir, with four-party  
agreements it's \$17.25 per quarter.

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THE CHAIRMAN: That would be \$70 a year  
for the four persons. That is in-hospital coverage?

7

8

MR. MAJOR: That is in-hospital non-  
group coverage.

9

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THE CHAIRMAN: Have you an income limita-  
tion on that?

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12

MR. MAJOR: Yes sir.

13

THE CHAIRMAN: Income limitation provi-  
sion being what?

14

MR. MAJOR: \$7,000 for the single indivi-  
dual and \$10,000 for the family.

15

16

THE CHAIRMAN: Are you able to give us  
some idea of the extent to which this extra billing is  
practised under this income limitation provision in your  
contract?

17

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19

MR. MAJOR: From a practical basis,  
Mr. Chairman, if we consider the only guide we have, that  
is complaints of the citizens.---

20

21

THE CHAIRMAN: No, I am not talking about  
complaints. They may not have any complaints at all but  
in the way the accounts come to P.S.I., do they or do  
they not show that there is over-billing in fact?

22

23

24

MR. MAJOR: No, they do not show this,  
sir. Some accounts come in higher than what the approved  
schedule may be but we have no verification that there is  
an extra billing that takes place.

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THE CHAIRMAN: When such an account comes

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in what do you do with it? How is it processed? Does  
P.S.I. pay what it should pay?

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MR. MAJOR: Yes.

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THE CHAIRMAN: Then what does it do  
about the balance? Does it tell the subscriber he is  
responsible for it or does he tell the doctor that he  
collect the balance?

10

MR. MAJOR: No. That is a little outside  
our sphere, Mr. Chairman. We have our agreement and we  
expect the subscriber understands his agreement. We  
expect that the physician understands his agreement and  
we leave this arrangement of the extra billing between  
doctor-patient as is ordinarily carried on in the private  
process of medicine.

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THE CHAIRMAN: In any event, you have  
kept no statistical records of it?

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MR. MAJOR: No, sir.

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THE CHAIRMAN: What about complaints now?  
What about those? We come from the general to the parti-  
cular.

21

MR. MAJOR: We have very few.

22

THE CHAIRMAN: That is from your subscriber?

23

MR. MAJOR: That is correct, sir.

24

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THE CHAIRMAN: What is the proportion  
of your coverage as between your group bodies, group  
membership, and your individual membership?

26

MR. MAJOR: Well, our group membership ---

27

28

THE CHAIRMAN: You have a large member-  
ship?

29

MR. MAJOR: Yes, as set forth on page 13

30



in what he was doing with it? Is it possible that  
it was what it should be?

THE CHAIRMAN: Yes.

THE CHAIRMAN: Now what was the  
about the balance? Was it the same as the  
responsibility for it or was he responsible for it?

THE CHAIRMAN: Now, that is a little different  
our system, Mr. Chairman. It has our system and we  
expect the supervisor to be his responsibility  
expect that the supervisor is responsible for the  
we have this arrangement on the system. Between  
doctor-patient is a relationship of a doctor and  
process of medicine.

THE CHAIRMAN: In any event, you have  
kept no statistical records of it?

THE CHAIRMAN: What about covering the  
what about those? Is there any general to the public  
claim?

THE CHAIRMAN: We have very few.

THE CHAIRMAN: Now is there any other information?

THE CHAIRMAN: What is the situation, sir?

THE CHAIRMAN: What is the situation?

THE CHAIRMAN: Now, you have your own system. You  
are working, and you are working on the system.

THE CHAIRMAN: Now, you have your own system. You

THE CHAIRMAN: Now, you have your own system. You

THE CHAIRMAN: Now, you have your own system. You





Major

9015

our total enrolment at the end of 1961 was 1,417,000 individuals. We call them participants.

THE CHAIRMAN: Yes, 1,417,000?

MR. MAJOR: That is correct. At the same time ---

THE CHAIRMAN: That is your total and then you have 1,186,000 - 686,000 - so you have 230,800 individuals, I take it?

MR. MAJOR: I don't follow that, sir.

THE CHAIRMAN: I was just taking the Tables 1 and 2 and subtracting one from the other.

MR. MAJOR: Yes, but that does not give you the distinct figure of the non-group enrolment which I thought you were heading for.

THE CHAIRMAN: Yes. You have total enrolment. You have group enrolment?

MR. MAJOR: Correct.

THE CHAIRMAN: I merely subtracted one from the other. What else should I have done?

MR. MAJOR: Well, you have included in the 212,000, round figures enrolment, the group conversions, go onto a paid direct basis, come down to what we call the non-group. This is an individual approach. You would have 19,158 as set forth on page 11, paragraph 76.

THE CHAIRMAN: The non-group plan, what you say there is the first subscribers to the non-group plan were effective May 15th, 1958. As of December 31st, 1961, there were 7,707 subscribers, with 11,451 dependents, for a total of 19,000. During the life of the plan, a



our total enrollment at the end of 2011, 2012,

2013, 2014, 2015, 2016, 2017, 2018,

2019, 2020, 2021, 2022, 2023, 2024, 2025.

same time --

THE CHAIRMAN: Yes, it is your turn.

Then you have 1,234,567 -- 1,234,567 -- 1,234,567 --

individuals, I think.

MR. WATSON: I don't follow that, sir.

THE CHAIRMAN: I am just asking the

Table 1 and 2 and comparing one row to the other.

MR. WATSON: Yes, but that does not give

you the exact figure of the non-group enrollment which

I thought you were reading for.

THE CHAIRMAN: Yes. You have total

enrollment. You have group enrollment.

MR. WATSON: Correct.

THE CHAIRMAN: I merely subtracted one

from the other. What else should I have done?

MR. WATSON: Well, you have included in

the 1,234,567, total figure enrollment, the group enroll-

ment, you have a small group basis, some down to what we

call the non-group. This is an individual enrollment.

You would have 1,234,567 as the total enrollment, and group

enrollment.

THE CHAIRMAN: The non-group enrollment, which

you say there is the first enrollment in the non-group.

plan were effective January 1, 2011. As of January 1, 2011,

there were 1,234,567 enrolled, with 11,111,111 in the non-

group for a total of 12,345,678. During the year of 2011, 1



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TORONTO, ONTARIO

Major 9016

total of 30,000 participants were enrolled. However,  
9,891 of these later cancelled their coverage.

MR. MAJOR: That is correct.

THE CHAIRMAN: Can you give us the  
reasons? I know you say for reasons best known to them-  
selves, but this looks like a fairly heavy percentage  
cancellation. What is the reason?





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/C/ss

9017

MR. MAJOR: We do not know. We wish we did have some reasons, but we find it impossible to obtain from people through any kind of a survey a commitment that they took certain actions because of certain specific reasons. Usually they pay no attention to the requests so we have no idea why these people willingly discontinue payment of their coverage.

THE CHAIRMAN: I just want to say again, our purpose is not to be critical of your operation, we admire the operation.

MR. MAJOR: That is correct and we realize that. We are as much in the dark on the motivation of the public as anybody is, and we have no reasons. We put this forward as an honest statistic, 30% of these people apparently for some reason or another after a passage of time have decided to either automatically not pay or for some reason or other have cancelled their agreement. These people may have written in and told us they were cancelling, but these are very few. We have no honest suggestion to give to you as to why one-third of the population enrolled in this non-group agreement should discontinue their coverage which originally they wanted, so they must have had some motivation to pay for it. Now we are interested in why this is not continued as a desirable item in their lives and we do not know.

THE CHAIRMAN: Mr. Major, in general figures are you in a position to say what the non-group segment of the population of Ontario is to what you might call the group segment, that area could be covered under the group plan as distinct from those who must obtain their



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Q. Now, I do not know, I wish

as this have come to pass, but we find it impossible to

obtain from the group any kind of a money

commitment that they have decided because of

general specific reasons. Usually they say no intention

to the extent so we have no idea why these people

willingly chose to be a part of their coverage.

A. That is

admits the operation.

Q. Now, that is correct and we

realize that, we are as much in the dark on the motivation

of the public as we are, is, and we have no reason. We

put this forward as an honest statistic, 80% of these

people apparently for some reason or another after a

passage of time have decided to either automatically not

pay or for some reason or other have cancelled their agree-

ment. These people may have written in and said as they

were cancelling, but there are very few. We have no

honest suggestion to give to you as to why one-third of

the population cancelled in this non-group coverage agreement and

discontinued their coverage which originally they wanted,

so they must have had some motivation to pay for it. Now

we are interested in why this is not continued as a

desirable item in their lives and we do not know

A. That is, I believe, in general.

Q. Now, you in a position to say what the non-group

segment of the population of Ontario is or what you might

call the group segment, that area could be covered under

the group plan as distinct from those who must obtain their



Major 9018

coverage as individuals? You have a population of 6,000,000 some to start with.

MR. MAJOR: Well, sir, I cannot remember my statistical tables. We take all groups eligible under P.S.I. for either the brown or blue plan and we would be considering all employed persons in groups of five or more throughout the Province of Ontario, and this must cover a tremendous number of the population.

THE CHAIRMAN: Does it cover half the population?

MR. MAJOR: Oh, more than that. I would be tempted to say it would cover close to -- it would be close to more than three-quarters of the population. I am sorry we did not work that into the submission because coverage on this could be obtained from the Dominion Bureau of Statistics.

THE CHAIRMAN: Well, in round figures you have about 4,500,000 who might well come under the group plan?

MR. MAJOR: That is right.

THE CHAIRMAN: So we have about another one and a half million to two million who would be outside the possibility of being insured under the groups, so that we have a considerable number of people. This is more than the population of several provinces of Canada. You have been insuring those, taking subscribers since the 15th of May, 1958, that is four years ago almost to the day. What does your graph show? Are you going up or have you levelled off, or what?

MR. MAJOR: Which graph would this be?







Major 9019

THE CHAIRMAN: The non-group.

MR. MAJOR: The enrolment or the cost?

THE CHAIRMAN: Your enrolment, the number of live subscribers who are keeping their membership alive.

MR. MAJOR: It is a gradual growth, but not sweeping, not nearly as sweeping as the group growth.

THE CHAIRMAN: We are now reaching about 1% of the population with this coverage. I see from Table 6 you have 5,723 participating physicians and this is out of a total of what? What is the total physician population in the Province?

MR. MAJOR: Well, sir, this is not such an easy figure to arrive at.

THE CHAIRMAN: We had the evidence yesterday afternoon from the Ontario Medical Association people that they have a membership of 7,500 out of 11,000 some-odd.

DR. LOCKHART: 8,156 and about 1,300 salaried physicians, and we feel that leaves roughly, and we have not been able to get an accurate figure, of 6,800 doctors in private practice in Ontario.

THE CHAIRMAN: And you have 5,700?

DR. LOCKHART: Right.

THE CHAIRMAN: Do you visualize this P.S.I. might take some form of a premium subsidy to provide coverage for those over 64?

DR. LOCKHART: Well, to certain elements of that over 64 group.





Lockhart 9020 9020

THE CHAIRMAN: To those who wish a coverage? You say you are making coverage available and it is available to somebody who can pay for it.

DR. LOCKHART: That is a point I was making, possibly a subsidy to those people over 65 or any other group who cannot afford to pay for the coverage themselves in one way or another.

THE CHAIRMAN: And you say that is a practical thing in the operation of a doctor-sponsored medical care program?

DR. LOCKHART: I think it could become a practical thing, yes.

COMMISSIONER FIRESTONE: If I may follow up this line of questioning. I thought it might help me a little if we could have a bit of explanation as to the operations of P.S.I. and then tie it in with some possible evolutionary changes, the sort of thing the Chairman has been talking about. To start out, what is the process of billing and payment? Is the arrangement that all participating physicians at the end of the month submit a bill to P.S.I. and that bill is then paid? Is that the process?

MR. MAJOR: That is correct.

COMMISSIONER STRACHAN: To the physician?

MR. MAJOR: To the physician. Pardon me, let us clarify it; there are two kinds of physicians as far as P.S.I. is concerned, in the Province there is the participating physician which you refer to in Table 6 and the non-participating physician. The participating physician is paid directly, Doctor Strachan, by the







Major 9021

Corporation; the non-participating physician is not paid directly, the payment is made to the agreement holder, the subscriber.

COMMISSIONER FIRESTONE: If I may follow on with this question? Taking the participating physician as the norm, I gather that 5,700 of 6,800 practising physicians are operating under the plan, that is the great majority, so let us deal with the great majority. This physician at the end of the month renders his account to P.S.I. and it is paid directly to the participating physician. I take it this procedure has been acceptable to the participating physicians and the patients. Have you had any complaints about the operations of this procedure?

MR. MAJOR: Minimal. There is always somebody to complain about any system, so we have that minimal area.

COMMISSIONER FIRESTONE: What kind of complaints have you encountered?

MR. MAJOR: They can fall into one or two categories, one that is common is "You have not paid us fast enough".

THE CHAIRMAN: That would be the physician?

MR. MAJOR: Yes, we are talking about payments to the physician. The other one is the physician may not have felt that the method in which we handled an account was handled in the way it should be handled. These would be the two complaints.

COMMISSIONER FIRESTONE: What does the





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Major 9022

latter complaint mean?

MR. MAJOR: Well, you might have or we might have humans processing these accounts and they are all subject to the human element. One of us may have made a misinterpretation of the application of the schedule and usually it is easily straightened out because it is either technical or misinterpretation.

COMMISSIONER FIRESTONE: Have you had any complaints from participating physicians or patients that the direct payment by P.S.I. to participating physicians has affected the quality of medical care service?

MR. MAJOR: No, sir.

COMMISSIONER FIRESTONE: From your own knowledge it does not affect the quality of medical care service, the fact you are paying directly to the physician?

MR. MAJOR: Not to my knowledge, sir.

COMMISSIONER FIRESTONE: Now, we learned yesterday that there are something like close to forty voluntary non-profit organizations providing medical care service coverage, would it be the case that some of your participating physicians would be rendering accounts to a number of these plans?

MR. MAJOR: That is possible.

COMMISSIONER FIRESTONE: I take it then when the end of the month comes a physician makes out a statement for this organization, for this non-profit medically sponsored organization and there are a number of these organizations, as we understood yesterday. Now, would you not feel that there is perhaps a good deal of







Major 9023

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4 duplication of effort involved with P.S.I. getting these  
5 accounts in, checking them, making out the cheque, the  
6 doctor having to make out a separate account and sending  
7 it in to one group, the second group will do the same in  
8 honouring the doctor's bills and a third and fourth and  
9 there are forty. I am not suggesting each physician is  
10 sending his account to forty organizations, it may be two  
11 or three or five, it depends on the kind of practice he  
12 has, but is, in your opinion, the existence of close to  
13 forty organizations in the Province of Ontario providing  
14 similar services in many cases similar plans and a lot of  
15 organizations trying to do the same job, would you not  
16 say there was a duplication of effort taking place at the  
17 present time?

18 MR. MAJOR: No, I would not say so.

19 COMMISSIONER FIRESTONE: Well, would  
20 you explain to us your views why you feel there is no  
21 duplication of effort taking place.

22 MR. MAJOR: May I clarify one point?

23 COMMISSIONER FIRESTONE: By all means.

24 MR. MAJOR: This duplication, of course,  
25 is not referring to the duplication of accounts from the  
26 same individual.  
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BL/hm

Major

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4 COMMISSIONER FIRESTONE: No, we are  
5 talking of coverage of the people of Ontario and the way  
6 the system works, and there are 40 organizations pro-  
7 viding similar services, with the same doctors,  
8 they don't get any more numerous, and the whole problem  
9 is that there are 40 groups collecting money and taking  
10 out, and my question is, is not a lot of duplication  
11 of effort involved and extra cost and uneconomic operation  
12 when it costs money to collect it, because it is the  
13 same group? Could you give us your views?

14 MR. MAJOR: Well, sir, we would have  
15 to rule out for the sake of argument the fact that any  
16 one of these organizations is not efficiently operated;  
17 you have to take them to be operating at an efficient  
18 standard and on an efficient basis. We must assume  
19 that to make sense to the discussion.

20 COMMISSIONER FIRESTONE: I will come  
21 back to that point.

22 MR. MAJOR: Yes, we can come back to  
23 that point. This is a matter of business principle as  
24 to whether or not central control is more efficient  
25 than decentralization. It would be difficult to say  
26 that one system is better than another. The finest  
27 business brains we have in the country could possibly  
28 be separated on coming to this decision. They may come  
29 to two different decisions, and one organization may  
30 say that decentralization with a series of branches  
would do a more efficient job than a central organiza-  
tion without the branches.

Now, there is no reason to believe that







Major

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4 if 100,000 people in one part of Ontario are covered by  
5 plan A and another 300,000 in another part of Ontario  
6 covered by plan B, that the amalgamation of these two  
7 organizations would make a more efficient operation.  
8 This would not necessarily be so. For the sake of  
9 argument, if we wanted to take one standard indicating  
10 the efficiency of both organizations, the percentage  
11 operating cost per premium income, let's say that they  
12 are both running at 8%, the amalgamation of these two  
13 corporations wouldn't necessarily lower the 8% of the  
14 double premium income.

15 COMMISSIONER FIRESTONE: You say not  
16 necessarily, but it could.

17 MR. MAJOR: If they are efficient  
18 organizations it is doubtful if it would. If we take  
19 another standard of indication of efficiency, the cost  
20 per month of operation, let's say it is 14¢ per month  
21 per person, then the amalgamation of these bodies and  
22 souls of these 100,000 there and 300,000 there wouldn't  
23 lower the operating cost of 14¢ per month per person.  
24 It wouldn't be logical that it should.

25 So I think that your question should  
26 be boiled down to the basis of whether or not a particular  
27 type of organization would be more efficient on a  
28 centralized basis than on a decentralized basis, whether  
29 one office should handle all the operations of the  
30 corporation across the province or whether you have  
one central office to administer all branches.

31 COMMISSIONER FIRESTONE: If I may  
32 continue. How does P.S.I. operate province-wise?





Major

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4 MR. MAJOR: We operate on a centraliza-  
5 tion basis.

6 COMMISSIONER FIRESTONE: Have you  
7 found this an efficient system?

8 MR. MAJOR: Yes, sir.

9 COMMISSIONER FIRESTONE: Now, if one  
10 physician has patients that are covered, let's say, by  
11 plans operated by five different organizations and at  
12 the end of the month he sends out five accounts, they  
13 are processed five times and five cheques are issued  
14 to him and it goes back. Now, if P.S.I. were to handle  
15 the work of these five groups, he would make out one  
16 account, it would be sent to P.S.I. and it would be  
17 processed and one cheque would be issued. Would you  
18 say that the preparation of five statements and the  
19 examination of the statements by five different  
20 organizations and issuance of five cheques is more  
21 efficient than the issuance of one statement and one  
22 cheque?

23 THE CHAIRMAN: I think you have to  
24 accept that there is a fallacy in your statement, Dr.  
25 Firestone, with respect, that the five -- whether the  
26 bill is for one or for five, it will be for X number  
27 of patients, and the processing is of the patient's  
28 account, whether by the clerk in A office or B office  
29 or C office. They are going to process 20 or 30  
30 patients' accounts, not one account. There would be  
no saving in the processing of the individual account;  
there would be a saving sending out one bill and one  
cheque.







Major

9027

COMMISSIONER FIRESTONE: This is the question that I have directed at the witness.

THE CHAIRMAN: Oh, no, you put it that the processing would be only one, that the processing would be limited, cut by four.

COMMISSIONER FIRESTONE: Now, sir, if this was the impression I gave, that was not the impression I was prepared to give.

The question I am asking you, sir, is that there will be one cheque issued and one account rendered instead of five accounts and five cheques. Now, this is my question. Would you care to answer it?

MR. MAJOR: It would be more efficient.

COMMISSIONER FIRESTONE: Thank you very much. So could I conclude from this that an economy could be achieved if these 40 organizations operating somewhat similar plans in the province could be reduced in numbers?

MR. MAJOR: Well, Professor Firestone, you are now coming back to the argument ---

COMMISSIONER FIRESTONE: I am just asking questions, no argument whatsoever. We are trying to learn from you whether there are economies possible, because I would like to tie in at the end what the Chairman is after. We are trying to find a system that would provide efficient coverage for the people of the Province of Ontario, and we are coming to you for guidance.

THE CHAIRMAN: I don't want it implicit from what you have said that I am suggesting one

THE PROBLEM OF THE FUTURE

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Major

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4 monolithic organization.

5 COMMISSIONER FIRESTONE: No, this is  
6 not the Chairman's question. This is the question I  
7 am directing to you, sir.

8 MR. MAJOR: This comes back, sir, to  
9 a matter of reconciling various applications, systems  
10 and methods where it is quite possible in an overall  
11 system to decide that a particular phase of that system  
12 could be more efficient, but it can lose its efficiency  
13 in an attempt to reconcile it to other phases of the  
14 system. There is no doubt that it would be more  
15 efficient in respect of one phase of billing from a  
16 particular physician's office that he would save one  
17 or two letterheads, he would save the trouble of typing  
18 two addresses on the letterhead instead of one. On  
19 the other end of it, you would gain this efficiency  
20 by issuing one cheque instead of three. Now, if those  
21 were all the problems in the department, yes, there  
22 would be some argument that this system would be more  
23 efficient.

24 COMMISSIONER McCUTCHEON: It is still  
25 an argument.

26 MR. MAJOR: Yes, it is still an  
27 argument, because this particular small segment must  
28 be reconciled to the multitudinous workings of a system  
29 and it must work to a total, and you come back to the  
30 argument whether or not it is best to decentralize or  
not. Do I make myself clear?

COMMISSIONER FIRESTONE: Yes, but  
you were explaining to us that P.S.I. was not decentralized.







Major

9029

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4 So all I am asking you is why could this system not be  
extended further?

5 MR. MAJOR: But we consider this an  
6 efficient system because it would be inefficient to  
7 decentralize and have us pay doctors' bills from various  
8 locations in the province.

9 COMMISSIONER FIRESTONE: Now, having  
10 decided this for yourselves, why could you not extend  
11 this efficient system to other groups?

12 MR. MAJOR: You mean by bringing their  
operation to us?

13 COMMISSIONER FIRESTONE: Yes, by  
14 entering into discussion and saying: "If we were to  
15 join maybe we can achieve economies and we can spread  
16 the risk further and we can provide more efficient  
17 service and coverage to the people." Have you considered  
18 entering into discussion about amalgamation with other  
19 voluntary and non-profit groups?

20 MR. MAJOR: Well, I wouldn't be honest  
21 if I say we hadn't considered it. I have also considered  
22 buying a Cadillac car, but I can't afford it. The  
23 consideration in this area is only worthwhile if there  
24 is some common meeting ground in which the two people  
25 willing to discuss this can meet, and there is at the  
26 present time no common meeting ground. Now, this may  
27 be for many reasons, and we don't know. We find that  
28 in this society in which we live there is a certain  
29 pride of authorship. After all, university football  
30 teams combat for a pennant, a cup, championship, and  
there is a certain pride in the local organization and



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to all I am not sure why could not have been  
external, perhaps.

Mr. [Name] - But we could have the same  
efficient system, but it would be the same in  
centralized and have no say because this is on various  
locations in the province.

Mr. [Name] - This is the same, but  
decided this for yourselves, why could you not see  
this situation as far as other groups.

Mr. [Name] - You mean the  
operation to get

entering into discussion and saying, "We were not  
told maybe we can achieve economies and we can share  
the risk further and we can achieve more efficiency."

entering into discussion about cooperation with other  
voluntary and non-profit groups.

Mr. [Name] - Well, I wouldn't be happy  
if I say we haven't considered it. I have also considered

trying a [Name] and can, but I can't afford it. The  
consideration in this area is only whether or not  
is some common meeting ground, and the two parties  
willing to discuss this contract, and there is at the  
present time no common meeting ground. Now, this is  
for many reasons, and we don't know, we don't know  
is this a really a [Name] or is it a [Name]  
rights of authors for [Name] and [Name] [Name]  
take control. For a person, a [Name], [Name], [Name]  
there is a [Name] in the local organization.



Major

9030

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3 particularly in these rural, farm organizations who  
4 have started co-operative schemes, and they are not  
5 too happy for anybody to suggest to them that they  
6 would lose their identity even though they would have  
7 their personnel absorbed, they would not be too happy  
8 being gobbled up by some organization in Toronto known  
9 as P.S.I.

10 So whether or not there would be  
11 efficiency gained or to be gained has never been  
12 arrived at because there has been, in thinking, no  
13 reasonable approach to come to a common meeting ground  
14 with these people.

15 Now, I have extended my own personal  
16 thinking. It hasn't even been suggested that it be  
17 tried.

18 COMMISSIONER FIRESTONE: You see, Mr.  
19 Major, we are coming now to the crux of the problem.  
20 Let's assume that the government of the Province of  
21 Ontario is thinking of a comprehensive medical care  
22 plan on a voluntary basis with some federal assistance  
23 and it requires an agency to administer this program;  
24 and let's further assume that this program provides  
25 that those who can pay the premium pay the premium and  
26 those that cannot pay it in full or in part have that  
27 premium paid out of government funds. Well, sir, if  
28 there was one organization that represents a large number  
29 of people, it would be easy to deal with this one  
30 organization, and let's assume that the government were  
to approach P.S.I. and say to you: "Would you be  
prepared to be the administering agent for this program





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participating in these work, I am convinced that we will  
have shared co-operative success, and they will not  
too easily for money or reward to them that they  
would not have been able to do it. They would not be  
their personal reasons, they would not be too easily  
being handled up by some organization in order to know  
as B.C.I.

In addition to the work of  
efficiency gained in to be earned has never been  
arrived at because there has been, in fact, no  
reasonable approach to one to a common machine which  
with these people,  
Now, I have extended to our organization

thinking, it hasn't even been suggested that it is  
this.

Now, we are coming now to the crux of the problem.  
Let's see what that the government of the Province of  
Ontario is thinking of a comprehensive plan. I am  
plan on a voluntary basis with some Federal aid. I am  
and it requires an agency to administer this program;  
and let's further assume that this program is to be  
that there will be pay the person pay the program in  
that that can pay it in full or in part over time  
program paid out of government funds, that is, the  
there are no special action that requires a change in  
at people, it would be easy to deal with that  
of course, and let's assume that the government is  
to pay the B.C.I. and pay to you. "Let's see  
proposed to be the same and the same."



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Major

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and we will assist in the financing of the program of  
those that can't pay for it or can only pay in part."



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/PB/hm

Major

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4 If they are for the plan how can  
5 government take care of people that are entitled to have  
6 their premium paid unless they participate in almost  
7 40 plans? It comes back to the question that I have  
8 been after: It isn't only a question of efficiency.  
9 I am personally convinced it will be a very efficient  
10 system and involves spreading risk. This is a personal  
11 opinion and something subject to enquiry and investiga-  
12 tion and confirmation, but there is the other basic  
13 problem, looking toward the future, that if the Province  
14 of Ontario is to get a medical care plan you need an  
15 administrating agency, and if one uses the voluntary  
16 agency one would like to have an agent that is  
17 representing all the plans and requirements of the people  
18 of the Province of Ontario. This is the crux of the  
19 problem. Therefore the question arises what are the  
20 possibilities, looking to the future, looking to the  
21 future needs, what are the possibilities of a co-operative  
22 effort of these 40 organizations? I don't know whether  
23 it means absorption by P.S.I. or a multiple group that  
24 would cover them or something that would provide the  
25 administrative vehicle to allow governments to turn to  
26 people who have had experience in the field of  
27 administrating such a plan with government help? Have  
28 you any thoughts on this?

29 MR. MAJOR: Professor Firestone, you  
30 have brought up a lot of points.

COMMISSIONER FIRESTONE: We have come  
to your organization -- this is the problem and you are  
an officer in Ontario and we would like to have some





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Major

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idea of how to come to grips with it.

MR. MAJOR: From a business standpoint?

COMMISSIONER FIRESTONE: Exactly, sir.

MR. MAJOR: There is no reason to believe that the amalgamation, if you put amalgamation in quotes, could take place and produce an efficient organization.

COMMISSIONER FIRESTONE: It could or could not?

MR. MAJOR: It could, yes.

COMMISSIONER McCUTCHEON: Or they believe it could?

MR. MAJOR: We are not saying they would. There is no reason that you couldn't consolidate all these plans and develop a reasonably efficient organization within the tolerance of force that a manager of an organization would ordinarily be held to in respect to reporting to the Board. Correct?

COMMISSIONER FIRESTONE: Correct, sir.

MR. MAJOR: Does that answer the question?

COMMISSIONER FIRESTONE: I would like to go further: Would you then feel, assuming that such a consolidated organization is created, would that sort of organization be in a position to administer such a medical care plan to which the Provincial Government would make a contribution in terms of premium payments for those that could not pay their premiums in full or in part?

MR. MAJOR: From a business sense it is



idea of how to come to grips with it.

Mr. W. H. [unclear] a business [unclear]

Mr. [unclear]: There is no reason [unclear]

believes that the organization, it is a [unclear] [unclear]

in [unclear], [unclear] [unclear] [unclear] [unclear] [unclear]

could [unclear]

Mr. [unclear]: It [unclear] [unclear]

Mr. [unclear]: [unclear] [unclear] [unclear]

believes it [unclear]

Mr. [unclear]: He [unclear] [unclear] [unclear]

Mr. [unclear]: There is no reason that you couldn't [unclear]

all these plans and develop a [unclear] [unclear]

organization where the [unclear] [unclear] [unclear]

members of an organization would [unclear] [unclear]

in respect to [unclear] [unclear] [unclear]

Mr. [unclear]: [unclear] [unclear] [unclear]

question?

Mr. [unclear]: [unclear] [unclear] [unclear]

to go further: [unclear] [unclear] [unclear] [unclear]

a [unclear] [unclear] [unclear] [unclear] [unclear]

of [unclear] [unclear] [unclear] [unclear] [unclear]

medical care plan [unclear] [unclear] [unclear]

would make a contribution in terms of [unclear] [unclear]

for those that could not pay their [unclear] [unclear]

in [unclear]

Mr. [unclear]: [unclear] [unclear] [unclear]



Major

9034

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3 quite possible.

4 COMMISSIONER FIRESTONE: Would you  
5 feel that P.S.I. would be prepared to support such a  
6 proposal?

7 MR. MAJOR: Well, Professor Firestone,  
8 I don't set the policy of P.S.I. Like all other  
9 managers I am under instructions, so that what I say  
10 to you now is personal. It is not the opinion of the  
11 Association.

12 COMMISSIONER FIRESTONE: That is quite  
13 adequate, sir.

14 MR. MAJOR: I would also say P.S.I.  
15 as a corporation could accept the responsibility and  
16 perform the function you have intimated it would perform.  
17 This would have to be considered by the Board of P.S.I.  
18 in relation with organized medicine which is the parent  
19 of P.S.I. If these people are agreeable to the  
20 arrangement then instructions would automatically come  
21 down to management and the management would either  
22 follow the instructions or look for another job, as it  
23 were.

24 COMMISSIONER FIRESTONE: There are  
25 really two aspects, if I may explore them. The first  
26 one is the effort to create an organization which  
27 amalgamates or brings together many of the other  
28 organizations so that there would be one large organiza-  
29 tion that the Provincial Government could deal with.  
30 That is the first question. The second one is this  
amalgamated or larger organization would then take on  
the job of administering government funds, because that





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of the position.

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Feel that T. J. I. would be prepared to accept a

proposal?

I don't see the value of T. J. I. in the

business I am in as a consultant, as that would be

to you now is essential. It is not the opinion of me

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advises, and

W. J. I. I would also say T. J. I.

as a corporation would accept the responsibility and

perform the function you have indicated it would perform.

This would have to be considered by the Board of T. J. I.

in relation with the business which is the parent

of T. J. I. If these people are agreeable to the

arrangement then instructions would automatically come

down to management and the business and would either

follow the instructions or look for another job, as it

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really two aspects, if I may know them. The first

one is the effort to create an organization which

analyses or makes research work of the other

organizations so that there would be one large organization.

Then that the financial statement could be made

The second one is the

employment of larger organization would then take on

the job of administering government work, because that



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TORONTO, ONTARIO

Major

9035

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4 is what the premium payments of the indigent or  
5 medically-indigent are. Those are the two questions.  
6 I quite agree with you that these are decisions that  
7 the P.S.I. executive and the policy-making body has to  
8 decide on. If you were asked as a manager for your  
9 advice -- you have successfully managed this. It is  
10 your baby. You have created it from the beginning with  
11 your brains and your ten fingers and you have done a  
12 wonderful job. If you were asked what your advice is  
13 knowing the direction in which the requirements for  
14 medical care services and insurance and prepaid plans  
15 are going.

16 COMMISSIONER McCUTCHEON: Do you know  
17 the direction?

18 COMMISSIONER FIRESTONE: What advice  
19 would you offer? If I may have my question answered.

20 COMMISSIONER McCUTCHEON: I would  
21 like .....

22 COMMISSIONER FIRESTONE: May I just  
23 have this question answered. You are welcome to question  
24 after.

25 MR. MAJOR: I will answer the question  
26 from a very practical, honest approach, Professor  
27 Firestone.

28 COMMISSIONER FIRESTONE: This is most  
29 helpful.

30 MR. MAJOR: If this was put to the  
management of P.S.I. as a proposition all reference in  
respect to this proposition, all facts relative to it  
would be requested. When they arrived the management would



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is what the people of the United States  
are looking for. It is a very simple  
I desire to see you in the future as a leader  
the U.S. Executive and the policy-making body  
to be on. The way to be a manager for your  
division - you have to have a very high level of  
your body. You have to be able to do the thinking with  
your brain and your ten fingers and you have to be a  
worker. If you want to be a good worker, you have to  
know the situation in which the people are working for  
and you have to have a very high level of  
and a very high level of

the situation?  
COMMISSIONER OF DISTRICT: What division  
would you prefer? If I have a question answered.  
COMMISSIONER OF DISTRICT: I would  
like ....

have this question answered. You are welcome to question  
again.

MR. VALLI: I will answer the question  
from a very high level, honest and forthright, in fact  
COMMISSIONER OF DISTRICT: This is most  
helpful.

MR. VALLI: If this was not the  
a report of the U.S. Executive and the policy-making  
response to the question, and I would like to see  
would be required. When they are in the position of



Major

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4 take six months to study them. At the end of the six  
5 months I would be able to answer your question. I  
6 don't think that management would ever go so far as to  
7 make a snap decision at a Board meeting or a Committee  
8 meeting that would have so much importance for the  
9 future development of the association, either on the  
10 system or on the policy, so that offhand I can't answer  
11 your question. I would say it would need to have  
proper study, proper deliberation.

12 COMMISSIONER VAN WART: Is ease of  
13 management the most important thing in your policy of  
14 operation, ease of administration, to put it that way,  
or are the other policies the most important thing?

15 MR. MAJOR: You mean ---?

16 COMMISSIONER VAN WART: The policy,  
17 we heard the policy of ease of management, of  
18 administration now. Is that the most important thing  
19 in your voluntary system?

20 MR. MAJOR: I would say that is the  
21 least important thing. The corporation known as P.S.I.  
22 wasn't created to make a soft job for a manager so that  
23 administration would be easy and he wouldn't have any  
24 worries or have to work 24 hours a day. This wasn't  
25 the objective in creating P.S.I. The objective of  
26 P.S.I. was to render the service. Whether administration  
27 would find it difficult or simply was immaterial. Does  
28 that answer the question?

29 COMMISSIONER FIRESTONE: Mr. Major,  
30 if this proposal were put before the policy-making  
body of P.S.I. and you were called and you were asked





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the six months of the year, the first of the year

because I would like to know how much

don't think that management would ever be able to

make a good decision at a time when the management

question that would have to be asked is whether

future level of the economy will be better or

system or on the other hand, as I said, I don't

your question, I would say it would be a

proper study, proper decision.

the question is, what is the

management the most important thing in your

operation, as a management, to put in the

on a the other side of the coin is to put in

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Major

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3 the question do you consider such a broad scheme which  
4 involves the administration of government funds for the  
5 indigent and the medically-indigent because this is  
6 where the money would come from to pay for those people,  
7 would you say that you could expand your organization  
8 to provide those services on an expanded basis to cover  
9 everybody in the province? If this proposal were put  
10 to the policy-making body and they were to ask you  
11 as a manager could you set up an organization to do  
12 this efficiently, what would your answer be?

13 MR. MAJOR: Anything is possible in  
14 business, Professor Firestone. I would say the answer  
15 would be we could set up an organization that will  
16 perform these functions and do it efficiently.

17 COMMISSIONER FIRESTONE: Thank you  
18 very much, Mr. Major. On a question of policy, if I  
19 may address it to you, Dr. Lockhart: If such an  
20 approach were made to P.S.I. and, I realize that you  
21 cannot speak for P.S.I. on something that hasn't been  
22 discussed by P.S.I., by the Board as a whole, but have  
23 you any personal views that if you were approached  
24 by the Provincial Government with such a proposal, what  
25 would be your reaction?

26 DR. LOCKHART: The reaction would  
27 certainly be one to give it due consideration that such  
28 an important decision would be, to consider this in the  
29 realm of the Ontario Medical Association, the policy  
30 of P.S.I. and the business possibilities, and come up  
with an answer. On the basis of this type of an  
approach being compatible with the discussion yesterday  
from the Ontario Medical Association I think that it





Major

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4 would get due consideration and we would come up with  
5 an answer.

6 COMMISSIONER FIRESTONE: Do I under-  
7 stand that you are in favour of some system to be  
8 worked out to provide medical care coverage for the  
9 indigent and the medically-indigent?

10 DR. LOCKHART: Right.

11 COMMISSIONER FIRESTONE: And the  
12 premium for this coverage be paid by the government?

13 DR. LOCKHART: We feel this is the  
14 only source of the premium that can be paid for these  
15 people.

16 COMMISSIONER FIRESTONE: If the  
17 government came to you and said rather than us adminis-  
18 tering this scheme you people have an organization that  
19 you are running so efficiently and would you administer  
20 this on our behalf, would you personally recommend to  
21 accept this?

22 DR. LOCKHART: Yes.

23 COMMISSIONER FIRESTONE: You would.  
24 That is very helpful. I understand you can't speak for  
25 P.S.I. as a whole as it hasn't been discussed, but if  
26 other doctors felt like you presumably P.S.I. would  
27 carry out such a function?

28 COMMISSIONER STRACHAN: Are you making  
29 a final decision without consideration?

30 DR. LOCKHART: No, he asked from a  
personal point of view.

COMMISSIONER FIRESTONE: Exactly.

DR. LOCKHART: From a personal viewpoint.





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4 COMMISSIONER STRACHAN: You are not  
5 sure of that until you give that due consideration?

6 DR. LOCKHART: Not until we give it  
7 due consideration.

8 COMMISSIONER McCUTCHEON: The policy  
9 of P.S.I. is the policy of the Ontario Medical  
10 Association?

11 DR. LOCKHART: It reflects the policy  
12 of the Ontario Medical Association.

13 COMMISSIONER McCUTCHEON: P.S.I. is  
14 sponsored by the Ontario Medical Association and the  
15 majority of the members of your Board are appointed by  
16 the Ontario Medical Association?

17 DR. LOCKHART: Not in truth, no.  
18 Members of the Board are elected by the house of delegates,  
19 and the house of delegates are elected representatives  
20 from the province wide, who are, in the main, members  
21 of the Ontario Medical Association.

22 COMMISSIONER McCUTCHEON: In the main,  
23 whether by one step or two they represent the Ontario  
24 Medical Association?

25 DR. LOCKHART: Yes.

26 COMMISSIONER McCUTCHEON: Under those  
27 circumstances would you expect the Board of P.S.I. to  
28 take on enlarged functions in this field that were  
29 incompatible with the policies of O.M.A.?

30 DR. LOCKHART: That is right.

COMMISSIONER McCUTCHEON: Would you  
expect them to?

DR. LOCKHART: No, we wouldn't expect  
them to.



BY THE SECRETARY OF THE INTERIOR, BUREAU OF LAND MANAGEMENT, U.S. DEPARTMENT OF THE INTERIOR, WASHINGTON, D.C. 20500

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WHEREAS, it is the policy of the Department of the Interior to encourage the development of the public lands of the United States for the benefit and enjoyment of the people thereof;



Major

9040

COMMISSIONER McCUTCHEON: Thank you.

COMMISSIONER FIRESTONE: Dr. Lockhart, we are facing the problem of finding some form of administering such a broad medical care plan which will provide medical care services to everybody in the Province. My question has been directed whether in the development of such a plan the Ontario Government, working on its own or in co-operation with the Federal Government could rely on P.S.I. to carry on and undertake some of the administrative functions that would be involved. This has been the basis of my questions. Now, I understand from you until this matter has been considered, carefully considered by the Board one can't say yes and one can't say no, but I understood, giving us your personal views as a doctor and an officer of the group, your views are that you feel that P.S.I. could undertake such a function?

DR. LOCKHART: Yes.

COMMISSIONER FIRESTONE: Thank you. Now, sir, I have one other question to Mr. Major, if I may: That is a question relevant to the comprehensiveness of your coverage. You have various plans. Some are more comprehensive than others. What is the proportion of coverage in terms of the number of people that have comprehensive coverage and the number of people that have less than comprehensive coverage in your group plans?

MR. MAJOR: In the blue plans?

COMMISSIONER FIRESTONE: In the group plans.







Major

9041

R/dpw

MR. MAJOR: In the group plan, offhand sir, it's four times as great for comprehensive coverage. I don't attempt to remember these.

COMMISSIONER FIRESTONE: I think it is adequate for the question that I would like to follow up. Is there a trend in the direction of increased comprehensive coverage? Is there a direction to increasing the coverage or what is the direction that you are moving?

MR. MAJOR: Yes. I think that is true, Professor Firestone, that the trend is to comprehensive coverage.

COMMISSIONER FIRESTONE: In other words, you have evidence that there is a desire on the part of the people of Ontario to get comprehensive coverage, as comprehensive as you provide under your plan?

MR. MAJOR: Yes.

COMMISSIONER FIRESTONE: What does comprehensive coverage under your plan provide?

MR. MAJOR: Provides all the services rendered by a licensed medical practitioner.

COMMISSIONER FIRESTONE: Including specialist services?

MR. MAJOR: Correct.

COMMISSIONER FIRESTONE: Including physical and mental illness?

MR. MAJOR: Correct, sir.

COMMISSIONER FIRESTONE: Including preventive medicine and curative services?

MR. MAJOR: Correct.

COMMISSIONER FIRESTONE: Thank you very

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much.

THE CHAIRMAN: Dr. Baltzan?

COMMISSIONER BALTZAN: Gentlemen, I have no hypothetical question for you. I just would like to have one or two answers. 37 on page 5, payment of accounts to physicians, made to the physician in final payment, you say, full and final payment; do physicians receive, say, 100% in the schedule of fees? Are you able to operate under that scheme of giving 85% or 75%?

MR. MAJOR: At the present time, Doctor, the Board's regulation is passed by resolution that participating physicians' accounts be paid on 90% of the allowed amount.

COMMISSIONER BALTZAN: Thank you. 38 on the same page, again, we see something that we encountered before, although it's a reverse order. Income limits are currently set at an annual gross income of \$7,000 and \$10,000. I accept that. Up until now we have been hearing about minimal income for people who just can't afford to pay anything; in here you state an upper bracket figure where they can try to pay something over and above that.

My question to you: how do you arrive at 7 and 10 from the point of view of the individual who applies? How do you know that it's 7 or 10? Have you got a means test?

MR. MAJOR: No, sir.

COMMISSIONER BALTZAN: Do you accept his word? You ask for his financial position?

MR. MAJOR: No, sir. We do not attempt





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no hypothetical question for you. I just would like to  
have one or two answers. ... ..  
to physicians, made to the physician in final payment,  
you say, full and final payment; do physicians receive,  
say, 10% in the schedule of fees? Are you able to  
operate under that scheme of giving 10% or 15%?  
MR. MURPHY: At the present time, Doctor,  
the Board's regulation is passed by resolution and partici-  
cipating physicians' accounts be paid on 10% of the  
allowed amount.  
MR. MURPHY: Thank you, it is on  
the same basis. Again, we are something that we encounter  
before, although it's a reverse order. Income limits  
are currently set at an annual gross income of \$7,000 and  
\$10,000. I accept that. Up until now we have been  
hearing about minimal income for people who just can't  
afford to pay anything, in some you state an upper  
bracket figure where they can try to pay something over  
and above that.  
My question to you, how do you arrive  
at 7 and 10 from the point of view of the individual who  
applies? How do you know that it's 7 or 10? Have you  
had a study?  
MR. MURPHY: ... ..  
MR. MURPHY: ... ..  
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Major

9043

to ascertain the income of the subscriber.

THE CHAIRMAN: That is P.S.I.?

MR. MAJOR: P.S.I. as a corporation does not attempt to obtain this information.

COMMISSIONER BALTZAN: How do you know?

THE CHAIRMAN: It's the physician who over-bills, who bills over the amount paid.

COMMISSIONER BALTZAN: How do they arrive at this?

THE CHAIRMAN: It's the physician who does that.

COMMISSIONER BALTZAN: The physician tells you that?

THE CHAIRMAN: The physician does it himself. That is the way, isn't it?

MR. MAJOR: That is right.

THE CHAIRMAN: If he does it at all.

MR. MAJOR: In the doctor-patient relationship, Dr. Baltzan, the physician is free to carry on as he ordinarily would in private practice with anybody that he feels may make over these income limits. It is up to him then as to whether or not he would like to be forthright about it and say, "Well, Mr. Smith, what is your salary?" Mr. Smith is liable to have various answers to this but he and the doctor must settle their differences, what his salary is going to be. It is not up to the corporation to do that, Dr. Baltzan.

COMMISSIONER BALTZAN: That is a very fine way of doing it. Must be a very fine sort of patient-physician relationship.



to assist him in the process of the corporation.

THE CHAIRMAN: That is P.S.I.?

MR. MAJOR: P.S.I. as a corporation.

Does not attempt to obtain this information.

COMMISSIONER BATTAN: How do you know?

THE CHAIRMAN: It's the physician who

verifies, who bills over the amount paid.

COMMISSIONER BATTAN: How do they

arrive at this?

THE CHAIRMAN: It's the physician who

tells you that?

THE CHAIRMAN: The physician does it

himself. That is the way, isn't it?

MR. MAJOR: That is right.

THE CHAIRMAN: If he does it at all.

MR. MAJOR: In the doctor-patient

relationship, Dr. Battan, the physician is free to carry

on as he ordinarily would in private practice with anybody

that he feels may make over these income taxes. It is

up to him then as to whether or not he would like to be

low paid or about it and say, "Well, Mr. Smith, what is

your salary?" Mr. Smith is liable to have various

answers to this but he says the doctor must settle their

differences, what his salary is going to be. It is not

up to the corporation to do that, Dr. Battan.

COMMISSIONER BATTAN: That is a very

fine way of doing it. That is a very fine sort of patient-



Major

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4 COMMISSIONER VAN WART: What is the  
5 position of the corporation if a doctor is over-charging  
6 or extra-billing a patient who is in the low income  
7 bracket?

8 MR. MAJOR: If he is a participating  
9 general physician, the corporation will take action to  
10 rectify the situation and put the doctor-patient relation-  
11 ship, in respect to their agreement with P.S.I., on the  
12 basis that they should have been had action not taken  
13 place.

14 COMMISSIONER VAN WART: Still have then  
15 a responsibility for seeing that the right people are  
16 over-charged?

17 MR. MAJOR: No. Turn it around the  
18 other way. We have responsibility to make sure that the  
19 right - that certain people are not over-charged because  
20 of income limits.

21 COMMISSIONER McCUTCHEON: You mean over-  
22 billed, not over-charged.

23 MR. MAJOR: Over-billed. Extra-billed.

24 THE CHAIRMAN: If you had a complaint in  
25 that respect you would investigate it?

26 MR. MAJOR: Correct, sir.

27 THE CHAIRMAN: Dr. Strachan?

28 COMMISSIONER STRACHAN: You have  
29 mentioned different methods of payment to participating  
30 and non-participating physicians. Would the non-partici-  
pating group include specialists, in particular?

MR. MAJOR: No. In relation to the  
extra-billing, sir?





COMMISSIONER: What is the

position of the corporation if a doctor is over-charged, or  
on extra-billing a patient who is in the low income

MR. WATSON: If he is a participating

general physician, the corporation will take action to  
rectify the situation and put the doctor-patient relation-  
ship in respect to their agreement with H.S.A. on the  
basis that they should have been had action not taken

COMMISSIONER: Will you have them

a responsibility for seeing that the right people are

over-charged

MR. WATSON: Yes, I am in accord with

other way. We have responsibility to make sure that the  
right - that certain people are not over-charged because  
of income limits.

COMMISSIONER: You mean over-

billed, not over-charged.

MR. WATSON: Over-billed. Over-billed

THE CHAIRMAN: If you had a complaint in

that respect you would investigate it?

MR. WATSON: Of course.

THE CHAIRMAN: Dr. Strachan?

COMMISSIONER: You mean

mentioned different methods of payment to part of billing  
and non-participating physicians. Would the non-participat-

MR. WATSON: Yes, in relation to the

extra-billing, sir?



Major

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COMMISSIONER STRACHAN: Yes.

MR. MAJOR: No. I have no knowledge that there is any difference in billings for the non-participating physicians and participating physicians who are certificated specialists. I have no knowledge of such a difference.

COMMISSIONER STRACHAN: You have a goodly number of specialists participating in this scheme?

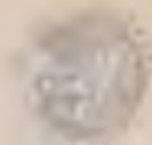
MR. MAJOR: That is correct.

COMMISSIONER STRACHAN: They are the ones who are most liable to do the extra billing?

MR. MAJOR: Well, they are the ones who have the privilege to do so. That's about as far as we can go.

COMMISSIONER McCUTCHEON: Mr. Major, as I understand it, leaving aside the people who leave a group and have the right to carry on, we will say, the group plan or the Brown plan, by making application to the corporation and pay the appropriate premium; if I come in and make application for a contract, the only contract you offer me is surgical, obstetrical and medical care in hospital. If I, as an individual.

MR. MAJOR: If you, as an individual, present yourself at the door of P.S.I. for a non-group agreement, you will have to make a couple of declarations. One is with respect to your age and the other is with respect to whether or not you are employed in a group of five or more common employees who have available to them the privilege of payroll deduction from a common payroll.



MR. MAJOR: Yes. I have no knowledge.

that there is any difference in ability for the one participating specialists and participating physicians who are not participating specialists. I have no knowledge of such a difference.

MR. MAJOR: You have a

poorly informed of specialists participating in this

MR. MAJOR: That is correct.

CONCERNING STRACHAN: They are the

ones who are most likely to do the extra billing?

MR. MAJOR: Well, they are the ones who

have the privilege to do so. That's about as far as we

can go.

I understand it, leaving aside the people who leave a

group and have the right to carry on, we will say, the

group then on the group plan, by making application to

the corporation and pay the appropriate premium; if I

come in and make application for a contract, the only

contract you offer me is a physical, osteopathic and medical

care in hospital. If I, as an individual,

MR. MAJOR: If you, as an individual,

contract yourself at the cost of P.S.I. for a non-group

contract, you will have to make a couple of definitions.

as to with respect to your age and the other is with

respect to whether or not you are employed in a group of

one or more common employees who have available to them

the privilege of payment of hospitalization from a common payroll.



Major

9046

COMMISSIONER McCUTCHEON: Let's say I am not. Let's say my age is under 65, nearest birthday, and I am self-employed.

MR. MAJOR: You would have an agreement without further questioning, as long as you paid the fee.

COMMISSIONER McCUTCHEON: Can I have a comprehensive agreement?

MR. MAJOR: No, sir.

COMMISSIONER McCUTCHEON: That is what I say. You limit the individual agreement to surgical, obstetrical and medical care in hospital?

MR. MAJOR: Correct.

COMMISSIONER McCUTCHEON: What is the reason? I take it you are familiar with other non-profit medical-sponsored plans in the Province of Ontario. Why does P.S.I. restrict its coverage to individuals in this way and other plans not restrict? Why are you saying to the self-employed individual that there is no way, as far as P.S.I. is concerned, of prepaying your normal medical bills with us? That is what you are saying.

MR. MAJOR: Mr. McCutcheon, there are several principles of insurance involved, although we are not an insurance plan.

COMMISSIONER McCUTCHEON: I know some of the insurance principles.

MR. MAJOR: Now, the principle element of the individual, through his own motivation, and we cannot read his mind, who walks into this organization and requests a particular type of coverage, would place us, as





...and I am not. But's say my age is under 65, not self-employed, and I am self-employed.

...You would have to be over 65 without further restrictions, as long as you have the fee.

...You would have to be over 65, and I am not.

...comprehensive as possible?

...Mr. Malloy: No, sir.

...Mr. Malloy: No, sir.

...say, you limit the individual's agreement to a certain.

...operational and medical care in hospital.

...COMMISSIONER: What is the reason? I take it you are familiar with other non-profit medical-sponsored plans in the Province of Ontario.

...Why does P.S.I. restrict its coverage to individuals in this way and other plans not restrict? Why a non-profit saying to the self-employed individual that there is no way, as far as P.S.I. is concerned, of providing you normal medical bills with us. What is what you are saying?

...Mr. Malloy: Mr. Commissioner, there are several principles of insurance involved, and it is not an insurance plan.

...COMMISSIONER: I know some of the insurance principles.

...Mr. Malloy: Now, the principle of the individual, through his own motivation, and we cannot treat him as a whole, who takes into his organization and requires a particular type of coverage, would be a



Major

9047

a business organization, in such a position that the anti-selection that would result from this type of enrolment would be harmful to the corporation as an operating concern.

We can carry that a step further by saying that this is harmful as long as we do not have a sufficient cross-section of the province, thereby having enrolled enough well people to take care of the ill people who, through their own motivation, wish to have their chronic conditions covered by home and office calls. If the statistical cross-section were large enough, then you could open this up so that there would be enough well people, statistically, to take care of the ill people who, through their illness, are motivated to get this coverage.

COMMISSIONER McCUTCHEON: Mr. Major, I understand the principles of anti-selection, adverse selection. Ideally, we should buy fire insurance the day before the house burns down. Buy life insurance the day before we die. Nevertheless, I can present myself and buy fire insurance. I can present myself and buy life insurance, subject, in both cases, to appropriate enquiries.

I may be wrong; if I am wrong, you just say so. Is it not true that other doctor-sponsored non-profit prepaid medical plans offer the individual, with whatever medical history they would ask for, I don't know, offer comprehensive individual contracts that would correspond in their benefits to your Blue plan?

MR. MAJOR: There is only one organization



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business organization, in such a position that the anti-  
 selection and would be a form this type of arrangement  
 would be similar to the corporation as an operating  
 concern.

We can carry out a step further by  
 saying that this is harmful as long as we do not have a  
 sufficient cross-section of the province, thereby having  
 another group well known to the rest of the ill  
 people who, through their own activities, wish to have  
 their own conditions covered by home and office  
 visits. In the statistical cross-section were large  
 enough, they would cover this up so that there would  
 be enough as I recall, statistically, to take care of  
 the ill people who, through their illness, are motivated  
 to get this coverage.

understand the principles of anti-selection, adverse  
 selection. Ideally, we should pay life insurance for  
 us before the house burns down. And life insurance  
 we know we die. Nevertheless, I can present myself  
 and pay the insurance. I can present myself and pay  
 life insurance, and, in both cases, to approximate  
 selection.

I am not wrong; if I am wrong, you just  
 say so. It is not true that other sector-sponsored  
 non-profit special medical plans often the individual,  
 with whatever medical history they would ask for, I don't  
 know, other comprehensive individual contracts that  
 would someone a third benefit to form of a plan.  
 Mr. MALCOLM: There is only one organization



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TORONTO, ONTARIO

Major

9048

that I know of that does this, sir, and that is the Windsor Medical Services.

COMMISSIONER McCUTCHEON: The Windsor Medical Services do it?

MR. MAJOR: That is correct, and they are a doctor-sponsored non-profit voluntary organization.

COMMISSIONER McCUTCHEON: Are they bordering on insolvency?

MR. MAJOR: No sir, but they are bordering on the statistical cross-section that we wish to achieve. They have reached the subjective. In other words, they have 85% of their area enrolled in this kind of coverage. They now can gamble with the other 15% without any difficulty.

COMMISSIONER McCUTCHEON: How do the commercial carriers carry on this type of business then?

MR. MAJOR: Is there any commercial carrier writing this type of business? Not to my knowledge, sir.

COMMISSIONER McCUTCHEON: Once we get beyond your income limits, every commercial carrier is. They issue an indemnity plan. All you have is an indemnity plan once you get beyond your income limits.

MR. MAJOR: An indemnity plan that also covers home and office calls without any underwriting?

COMMISSIONER McCUTCHEON: There is underwriting.

MR. MAJOR: That makes a difference.

COMMISSIONER McCUTCHEON: Wouldn't I be much better off if you would underwrite or do I have to





that I want to have this, and, in fact, I want

to have it in the same way

that I want to have it

Mr. [Name], that is correct, and this

and I am sure that you will find it very interesting

because it is very interesting

Mr. [Name], in fact, it is very interesting

on the other hand, it is very interesting and it is very

They have reached the objective. In fact, they have

have 80% of their total production in this kind of company

They now can gamble with the other 20% of it

activity.

COMMERCIAL BANKING: This is the

commercial banking company on this type of business

Mr. [Name]: Is there any commercial

company with this type of business? Not to my knowledge

(over)

COMMERCIAL BANKING: This is the

beyond your income limits, every commercial company

They are in the same way. All you have to do is to

then once you get out of the income limits

Mr. [Name]: An intensity plan that

covers both the office and the home

Mr. [Name]: This is the same plan

Mr. [Name]: This is the same plan

COMMERCIAL BANKING: This is the

much better off. You can get information on this



Major

9049

go down to Windsor to get the plan I want? That is the question I am putting to you.

MR. MAJOR: This underwriting, sir, is a little different. I think our definition of it may be different. It is quite possible for an insurance organization to accept an individual as a policyholder for health services. They will be in no fear of going bankrupt if they underwrite or rider the policy for the pre-existing conditions and the current chronic conditions that this person now has.

In other words, insurance is to insure you against the unknown, not the known, and I am sure you are aware of that, so that the underwriter of this type of insurance usually operates with a questionnaire as to the prospective policyholder declaring what his condition is and then they underwrite out of the benefits those conditions.

COMMISSIONER McCUTCHEON: They may or may not.

MR. MAJOR: Usually they do.



go down to London to get the plan I want. That is the  
question I am putting to you.

Mr. Wilson: This unwritten, sir, is

a little different. I think our definition of it may be  
different. It is quite possible for an insurance organiza-  
tion to accept an individual as a policyholder for health  
services. They will be in no fear of going bankrupt if  
they undertake to cover the policy for the pre-existing  
conditions and the current chronic conditions that this  
person now has.

In other words, insurance is to insure  
you against the unknown, not the known, and I am sure you  
are aware of that, so that the underwriter of this type  
of insurance usually operates with a questionnaire as to  
the prospective policyholder declaring what his condition  
is and then the underwriter out of the benefits those

conditions are not known. They may or may

not, Wilson: I really don't



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Major

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COMMISSIONER McCUTCHEON: I do not accept your statement that usually they do. However, your answer is, first, you only offer the individual this limited benefit and I take it it is going to be some considerable time, in your opinion, before you can offer the individual a truly comprehensive plan?

MR. MAJOR: I suppose the definition of "considerable time" is questionable. What that might be I do not know.

COMMISSIONER McCUTCHEON: Let us leave it at a considerable time. Thank you very much.

COMMISSIONER VAN WART: Is not your problem that those who are chronically ill and those who have some disability in the individual groups or over-65, they are your first applicants; it is not the person who is in good health? That is your problem, sorting this group out.

In the overall picture are there enough healthy people over 65 to carry this group which is your problem now?

MR. MAJOR: And you are speaking specifically of the over-65 group?

COMMISSIONER VAN WART: Yes, the over-65.

MR. MAJOR: Well, I think it is possible providing we reconcile various factors. I think the P.S.I. statistics are now reaching the stage where we could intelligently apply these statistics to the over age 65 individual and give a reasonable break. Let us say we could enroll them without question and we are very nearly there. Your assumption is correct and it might be,





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27. The twenty-seventh point is that...



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TORONTO, ONTARIO

Major

9051

regardless of age, that the usual non-group applicant has a particular motivation to get that and usually it is a current chronic condition, not always, because there are still a lot of people, relatively speaking, who are insurance-minded enough to protect themselves against future contingencies in health services.

THE CHAIRMAN: Thank you very much, Dr. Lockhart and Mr. Major. This is the day that we are devoting to the study of these health plans and you have been very helpful to us. We will continue, after a short recess with, Windsor Medical.

DR. LOCKHART: Thank you, Mr. Chairman.

--- Short Recess





9052

THE SECRETARY: We will now hear the Windsor Medical Services Incorporated and Mr. Walpole will present his group to the Commission. There submission will be known as Exhibit 243.

--- EXHIBIT NO. 243: Submission of Windsor Medical Services Incorporated.

SUBMISSION OF WINDSOR MEDICAL

SERVICES INCORPORATED

Appearances: Dr. E. Durocher  
Dr. E.A. Roemmele  
Dr. W.E. Hume  
Mr. W.V. Walpole  
Mr. A.F. Fuerth

MR. WALPOLE: Mr. Chairman and members of the Royal Commission on Health Services: we are here today to present the brief prepared by the Windsor Medical Services Inc. and to provide whatever information we are capable of providing in order to assist the Commission in carrying out its duties.

I would like to introduce the members of our group here. On my left is Dr. E. Durocher, President of Windsor Medical Services; on my extreme left, Mr. A.F. Fuerth, former Vice-President of Windsor Medical Services and now retired. On my immediate right, Dr. E.A. Roemmele, Vice-President of Windsor Medical Services and on my extreme right, Dr. W.E. Hume, our Medical Director.

With your permission I should like to read the summary of our brief and our recommendations and then we would be pleased to try and answer whatever questions you may have. Please feel free to direct your





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Walpole

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questions to any member of our group.

1. Our submission deals with a program for physicians' health services as provided by Windsor Medical Services Inc.

2. It is confined to the personal health services rendered by physicians as these relate to paragraphs (a), (b), (c), (h), (i) and (j) of Order in Council P.C. 1961-883.

3. It emphasizes the philosophy of voluntary prepaid medical care plans as conforming to the freedom enjoyed by Canadians.

4. It outlines the development and progress of Windsor Medical Services Inc. including the benefits available.

5. It demonstrates the desire of the public in our area for comprehensive physicians' services.

6. Certain problems are defined and suggestions are made to solve these.

7. Social and administrative research is stressed as part of our program.

8. Evidence is presented to show that through the sponsorship of prepaid medical care plans, such as Windsor Medical Services, the medical profession has been able to provide not only the physicians' services for our citizens but also a vehicle by which they can budget for these services.

#### RECOMMENDATIONS

1. That the provision to meet the cost of physicians' services, through the application of prepayment for services received from physicians in the private



question to any member of the group.

1. In any case there will be a program

for the group, and the services are provided by the group.

2. It is common to the general

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Walpole

9054

practice of medicine, remain on a voluntary basis.

2. That tax dollars be used to pay the premiums, in whole or in part according to need, for those persons in the marginal income group and the indigents.

3. That the voluntary prepaid medical care plans remove enrollment restrictions which deny coverage on the basis of age or health.

4. That the individual be encouraged through the exercise of his freedom and responsibility, to take advantage of prepayment of physicians' services as a means of protecting the health of himself and his family.

THE CHAIRMAN: Thank you very much, Mr. Walpole. Now, as I understand it, you were present when we were discussing the submission of P.S.I.

MR. WALPOLE: That is true.

THE CHAIRMAN: And while I am not conducting a parliament in that sense, we are prepared to hear from you if you have any observations to make on any matters which were brought up in the discussion. We do not want to just plough the same ground over again but we may necessarily have to do some of that. However, if there are some areas on which you wish to make some observations, either you or your colleagues, at this time we would be pleased to hear from you.

MR. WALPOLE: I think perhaps one of the areas in which we might lead off is perhaps in our non-group agreements. There seemed to be, as I gathered from the discussion as to whether this type of coverage should





12-10-1961

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Walpole

9055

be available to the general public on a non-group basis.

THE CHAIRMAN: I think you have correctly interpreted what must be regarded as a fairly large question.

MR. WALPOLE: We have, since 1959, been providing to the citizens of our area comprehensive physicians' services on a non-group basis. This has grown at a, you might say, moderate rate; we add approximately 300 bodies per month without any urging on our part.

We have no one in the field selling this, it is done strictly by pamphlets and so on, distributed through doctors' offices and banks and so forth. We now have some 11,000 persons covered in this program.

Up until recently we have had an age restriction which required that the subscriber or spouse should not have reached his 70th birthday. At a recent meeting of our Board this restriction was removed in its entirety and it might be of interest to know that I only happened to pick this one day and I do not know why I picked it, but there is an interesting bit of information contained in this.

This is on the 30th of April.

THE CHAIRMAN: This year?

MR. WALPOLE: Yes, this year. We received 63 applications for non-group coverage from persons over 70 years of age, the oldest being 105.

COMMISSIONER McCUTCHEON: You won't have to support him very long anyway.

MR. WALPOLE: One never knows with the





Walpole

9056

advances in medical science.

COMMISSIONER BALTZAN: Fewer people die at that age.

THE CHAIRMAN: Do you want to go further with this illustration?

MR. WALPOLE: To illustrate that a little further, I think it is interesting to note that two of these applications were for people 95 years of age and we have some between 95 and this figure of 82. We have four who are 82 and four who are 81 and six who are 80. We are making available the benefits of Windsor Medical Services comprehensive program to all citizens in our area without a statement of health or without an age barrier.

COMMISSIONER McCUTCHEON: I did not think anybody that old could afford to pay the premium. These people are paying the premium?

MR. WALPOLE: That is true.

COMMISSIONER STRACHAN: The same premium as for those under 70?

MR. WALPOLE: We have a level premium throughout.

THE CHAIRMAN: You limit your activity geographically to ---?

MR. WALPOLE: Essex and Kent Counties.

THE CHAIRMAN: And what percentage of the total population is now included within your coverage?

MR. WALPOLE: As at the date our brief was compiled we had 68.7% of the total population of these two counties covered.





11-10-1941

CONFIDENTIAL

SECRET

11-10-1941

Mr. [Name] [Address]

Dear Sir, I am in a position to report that

the following information was obtained from the

files of the [Organization] and the [Department]

on the 10th and 11th of the month of [Month]

and the following information was obtained from the

files of the [Organization] and the [Department]

on the 10th and 11th of the month of [Month]

and the following

CONFIDENTIAL

It is requested that you should refer to the

above information and the [Organization]

Yours faithfully,

Mr. [Name] [Address]

Yours faithfully,

CONFIDENTIAL

Yours faithfully,

Yours faithfully,

Yours faithfully,

Yours faithfully,

Yours faithfully,

Yours faithfully,



Walpole

9057

THE CHAIRMAN: Now, who do you not cover?

MR. WALPOLE: Our biggest area of difficulty is getting to the rural residents. In other words, to have the rural residents enrolled and we have not had too great a measure of success in campaigns to enroll the rural population in groups or in geographic areas. That seems to be our greatest area in which we do not have coverage.

THE CHAIRMAN: Is the non-group - can you tell from the applications coming in that you are now getting a reasonable proportion from the rural area in the non-group?

MR. WALPOLE: I would only have to go on an impression, I have nothing factual but we do have a fair number of rural applicants but what proportion I could not say.

THE CHAIRMAN: You had a look at your figures on April 30th?

MR. WALPOLE: Yes; not from a geographic standpoint. I was interested after we had lifted our restrictions.

COMMISSIONER McCUTCHEON: You stated a moment or two ago - you referred to the difficulty in enrolling the farm population on a group or non-group basis. I assume that you have devised rules for groups which would permit a particular substantial proportion of them to enroll on a group basis if they chose to be enrolled?

MR. WALPOLE: If there is some measure of ---





Walpole 9058

COMMISSIONER McCUTCHEON: Everybody delivering milk to one dairy or cream to one creamery; you are prepared to accept that kind of group?

MR. WALPOLE: Yes. I know we have two groups, in fact, where the ladies organization, the ladies institute, have organized, and it covers a certain segment and bounded by certain areas, and we have our quota in there.

COMMISSIONER McCUTCHEON: You go this far: you would define a group as everybody who lived on the 3rd Line in Whitchurch?

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...living with one lady or man to one person;

...I know we have

...in fact, when the ladies organization, the

...ladies organization, have organized, and it covers a great

...a great and founded by our own people, and we have our

...of them.

...COMMISSIONER: Yes, you talk

...you would get a group as everybody has the

...and the in which



H/ss

Walpole 9059

MR. WALPOLE: We have a group such as that, bounded by certain concessions.

COMMISSIONER McCUTCHEON: In other words, the whole idea that a group must have a common employer and one set payment has completely disappeared and all you are trying to do to give the people the benefits of the group rate is to set up some yardstick which will ensure against too much anti-selection.

MR. WALPOLE: Yes.

COMMISSIONER GIRARD: What would you say about any group that could get their premiums collected together and paid to you by one person? Would that come within the definition of a group?

MR. WALPOLE: We are speaking of groups now, I want to understand that, and just a group of people getting together wouldn't constitute a group, if that is what you mean. We must be able to define the group. In other words, it is people living within area A bounded by so and so, or they belong to an organization and pay dues, something like that, which gives them some degree of cohesion.

COMMISSIONER GIRARD: But even in this area A you are talking about the premiums would have to be paid by one person and paid to you by one person.

MR. WALPOLE: Yes.

COMMISSIONER GIRARD: And you are saving money that way.

MR. WALPOLE: Yes.

COMMISSIONER GIRARD: But they still have to have some kind of ----





Walpole 9060

MR. WALPOLE: Let's put it on this basis, that they must have what we refer to as a group leader.

COMMISSIONER GIRARD: You could have a group leader without them being in one area A. Suppose I as a nurse got fifteen other nurses together, and we are just nurses, that is all, and I say I will collect all the premiums and I will pay them to this organization so we would have a lower premium, would that be a group?

MR. WALPOLE: Not unless it was organized in some manner.

COMMISSIONER McCUTCHEON: Take all the nurses.

COMMISSIONER GIRARD: If you take all the nurses working under an employer, you would take that?

MR. WALPOLE: We cover the Nurses' Registry where there is some organization.

COMMISSIONER McCUTCHEON: Why do you make a distinction with respect to the right to extra bill between the holders of your group contract and holders of your individual contract?

MR. WALPOLE: May I clarify that also? At the same meeting as we removed our age restriction, those two contracts now coincide.

COMMISSIONER McCUTCHEON: Did you raise on the individual?

MR. WALPOLE: Yes.

COMMISSIONER McCUTCHEON: So it is seven and ten.

MR. WALPOLE: Seven and ten, that is right.





3055

WALTON

MR. WALTON: Let's put it on this

card, and they must have what we refer to as a group

card.

COMMISSIONER GIBBARD: You could have

a group card without them being in one area A. Suppose

if we have got fifteen other nurses together, and we

are poor nurses, that is all, and I say I will collect

all the premiums and I will pay them to this organization

so we would have a lower premium, would that be a group?

MR. WALTON: Not unless it was

COMMISSIONER GIBBARD: Take all the

nurses.

COMMISSIONER GIBBARD: If you take all

the nurses working under an employer, you would take them?

MR. WALTON: We cover the nurses.

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COMMISSIONER GIBBARD: Why do you

make a distinction with respect to the right to extra bill

between the holders of your group contract and holders of

your individual contracts?

MR. WALTON: May I clarify that also?

At the same meeting, as we remarked our age restriction,

these two contracts now conflict.

COMMISSIONER GIBBARD: Did you

refer to the individual?

COMMISSIONER GIBBARD: So it is

that is all.

MR. WALTON: Never and can, that is

right



Walpole 9061

THE CHAIRMAN: What is the extent percentage-wise, if there is any figure you can give us, of this extra billing?

MR. WALPOLE: Perhaps one of the doctor members could answer that.

DR. ROEMMELE: Mr. Chairman, this is something in our area which is very rarely used. There is the privilege, and it is sometimes a difficult thing for a doctor to establish with his patient, and rather than offend the patient the doctor accepts the usual medical fee. In the circumstances where the man is the president of Hiram Walker's, then there is no doubt about it. But I would think personally in my own practice it is a rarity; in talking to the doctors in our area I think it is certainly a rarity.

THE CHAIRMAN: With specialists, too?

DR. ROEMMELE: Everyone.

COMMISSIONER BALTZAN: When the bill is sent in to your organization by the physician it covers all that he charges including also the extra billing?

DR. ROEMMELE: No.

COMMISSIONER BALTZAN: Does he send two bills?

DR. ROEMMELE: No.

COMMISSIONER BALTZAN: One that he can derive from you and the other for the extra charge?

DR. ROEMMELE: If he treats a patient over this income limit, he submits it to Windsor Medical and his account card which will be the full fee for the medical. Windsor Medical has no way of knowing what he



THE CHAIRMAN: What is the extent

of this extra billing?

DR. WILSON: Perhaps one or two

percent more than the fee that

THE CHAIRMAN: Mr. Chairman, this is

something in our area which is very rarely used, and is

the contrary, and it is sometimes a difficult thing for

a doctor to establish with his patient, and rather than

extend the patient the doctor accepts the usual medical

fee. In the circumstances where the man is the president

of the hospital, then there is no doubt about it. But

I would think personally in my own practice it is a matter

in talking to the doctors in our area I think it is

certainly a positive.

THE CHAIRMAN: With specialists, too?

DR. WILSON: Everyone.

COMMISSIONER BARTON: When the bill

is sent in to your organization by the physician it covers

all that he charges including also the extra billing?

COMMISSIONER BARTON: Does he send

DR. WILSON: No.

COMMISSIONER BARTON: One last he can

leave out and the other for the extra charges?

DR. WILSON: It is a matter of patient

even this income tax, he submits it to Windsor Medical

and I don't know which will be the full fee for the

service. Windsor Medical has no way of knowing what he



Roemmele 9062

charges the patient, and if the patient is below that income limit then the patient will inform the doctor, and if there is any controversy about that there is a meeting with the Windsor Medical Board. If we prove that the patient is below that income limit the doctor cannot have that extra bill and he must be discontinued if he extra-bills that patient.

COMMISSIONER BALTZAN: Do you know if that is a common policy governing all physicians in pre-paid medical services?

DR. ROEMMELE: In other areas?

COMMISSIONER BALTZAN: Yes.

DR. ROEMMELE: No, this is our own.

COMMISSIONER BALTZAN: In most other areas the total bill is sent, the amount, the organization pays that and the patient is notified. So it is not a universal thing.

COMMISSIONER McCUTCHEON: Mr. Walpole, Paragraph 44 on Page 9, you refer to the present trend in psychiatric care and you say you haven't yet been able to incorporate total psychiatric care in your plan. As a matter of curiosity, I can't find the exception in the contract which would eliminate psychiatric care other than when I am in an institution.

MR. WALPOLE: We are not saying there we don't take anything towards or exclude anything towards our psychiatric treatment. We are saying there in essence we are not able to meet the scale required in psychiatric care. We do make a token payment, as mentioned in the paragraph, we do make a reimbursement, a payment.





...for a patient, and if the patient is below that  
...the patient will know the doctor,  
and if there is any controversy about that there is a  
meeting with the Wisconsin Medical Board. If we prove  
that the patient is below that income limit the doctor  
cannot have that extra bill and he must be discontinued  
...the extra-bills that patient.

COMMISSIONER BALTMAN: Do you know if  
that is a common policy governing all physicians in the  
paid medical services?

MR. ROBINETTE: In other areas?

COMMISSIONER BALTMAN: Yes.

MR. ROBINETTE: No, this is our own.

COMMISSIONER BALTMAN: In most other

areas the total bill is sent, the amount, the organization  
pays that and the patient is notified, so it is not a  
universal thing.

Paragraph 10 on Page 9, you refer to the present trend in  
psychiatric care and you say you haven't yet been able to  
incorporate total psychiatric care in your plan. As a  
matter of curiosity, I can't find the exception in the  
contract which would eliminate psychiatric care other  
than when I am in an institution.

MR. BALTMAN: As one not saying those

we don't take anything towards or exclude anything towards  
can psychiatric treatment, as one saying there is a reason  
we are not able to test the same. ... in psychiatric  
... we are making a total payment, as mentioned in the  
contract, we are making a total payment, a payment.



Walpole 9063

COMMISSIONER McCUTCHEON: If I hold your contract but I can't have any extra billing, I am not subject to any extra billing, and I go to the psychiatrist, say, a little oftener than you permit in Paragraph 44, what happens? Is the psychiatrist prorated? Surely I can't be billed for it?

MR. WALPOLE: We have a curious situation in our area in respect to that. None of our psychiatrists are participating physicians, and therefore we deal directly with the subscriber or the patient.

COMMISSIONER McCUTCHEON: That is your out, you are not dealing with the participating physician. So you pay the psychiatrist according to whatever your rules may be and I am left to pay the balance?

MR. WALPOLE: That is right, sir.

THE CHAIRMAN: Coming back to Mr. McCutcheon's question, where is it so stated in the bill? I mean in the contract?

MR. WALPOLE: I am afraid I don't quite follow your question.

THE CHAIRMAN: Paragraph 4, medical services available, medical care during illness of the type usually provided by the medical member chosen. You say it is because you haven't chosen any psychiatrists.

DR. DUROCHER: If the psychiatrist is a member of Windsor Medical he would have to accept monies paid at our rates and could not extra-bill the patient under our limit. If they made application to Windsor Medical they could become doctor members of Windsor Medical, there is nothing to keep them out.

COMMISSIONER OF HEALTH: If I could

your contract but I can't have any other billing, I can  
not object to any extra billing, and I go to the service  
unit, or a little closer than you permit in paragraph  
14, that agency. Is the psychiatrist involved? Surely  
I don't bill for it?

MR. WALSH: We have a complex situa-

tion in the area in respect to that. None of our  
psychiatrists are participating physicians, and there are  
no real directly with the supervision on the patient.  
COMMISSIONER OF HEALTH: That is very

well, you are not dealing with the participating physician.  
Do you pay the psychiatrist according to whatever your  
rates may be and I am left to pay the balance?

MR. WALSH: That is right, sir.

THE CHAIRMAN: Coming back to Mr.

Commissioner's question, where is it so stated in the bill  
I mean in the contract?

MR. WALSH: I am afraid I don't quite

know your question.

THE CHAIRMAN: Paragraph 14, section

seventeen available, medical care during illness or the  
time usually provided by the medical member chosen. For  
section 14, section 14, you haven't chosen any, psychiatrist.  
14. DUNCAN: If the psychiatrist is

not a member of the medical staff, would he be to accept  
of the medical staff and would not extra-bill the  
patient under any light. If they were a member of the  
medical staff, they would be under the medical staff of  
the medical staff, there is nothing to keep them out.



Roemmele 9064

DR. ROEMMELE: Mr. Chairman, there is no doctor excluded from Windsor Medical, any doctor of good standing with the College of Physicians and Surgeons is acceptable. He must accept our fee schedule.

THE CHAIRMAN: Why are psychiatrists not included?

DR. DUROCHER: Don't pay enough money.

THE CHAIRMAN: Accepting that mental illness is a large section of the illness picture, what must be the situation for the future in providing coverage for the mentally ill? Can we continue to segregate them and discriminate against them in this way?

DR. ROEMMELE: Mr. Chairman, in our area we have psychiatrists who, as you know, don't belong to the plan, and therefore when the patient goes to the psychiatrist Windsor Medical will reimburse the patient for a specialist rate as in the schedule and the patient is expected to pay the difference. Now, a great many mental illnesses are handled by doctors in our own area, which is a good thing in our opinion. We also have a mental health clinic sponsored by the Government, which is also a good thing, handles a great deal of work, but which unfortunately is a great deal over-loaded, needs more help. I personally think it is an excellent thing, and we are hoping that this will be enlarged and meet a problem which is a very expensive item for the patient and for the plan.

COMMISSIONER McCUTCHEON: If you have a psychiatrist as a participant, must he abide by the qualifications of Paragraph 44 on Page 9?





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Walpole 9065

THE CHAIRMAN: That is what Doctor Durocher has said.

MR. WALPOLE: By signing the participating physicians' agreement he agrees to accept our schedule.

COMMISSIONER STRACHAN: That may be the reason why you haven't got members.

DR. DUROCHER: It is one area where we hope to expand sometime in the future.

THE CHAIRMAN: And by this broadening of your coverage as you have mentioned, raise the income level, and so forth. Do you still carry clause 7 in the contract, that is the right of refusal?

DR. DUROCHER: Yes.

THE CHAIRMAN: And also Paragraph 24, that you may terminate the contract on 30-days' notice?

MR. WALPOLE: Yes, that is still in.

THE CHAIRMAN: How often is that used?

MR. WALPOLE: This termination of agreements is something which has been very, very rarely used. It is in there as a medium of control, and in my recollection there has been one subscriber and his family who lost their coverage for one month only, and others lost it and were reinstated back to the time it was cancelled on the basis of a promise that they might conform to the normal medical requirements.

THE CHAIRMAN: You have under the non-group terms under Paragraph 20, duration of service. But if and when it so appeared to the Corporation that a subscriber or any of his included dependents are making



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undue and excessive demands for services the Corporation  
may at its discretion cancel the agreement. Is that the  
clause you were referring to?





UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

1977

and excessive demands for services the corporation  
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Walpole

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4 MR. WALPOLE: Yes. May I cite one  
5 example where a subscriber was seeing three general  
6 practitioners in one day and doing that on several  
7 successive days. We applied that.

8 THE CHAIRMAN: That would be evidence  
9 that he really liked doctors, or something else.

10 COMMISSIONER McCUTCHEON: You could  
11 have sent him to a psychiatrist.

12 MR. WALPOLE: We have to safeguard  
13 ourselves against things like that.

14 THE CHAIRMAN: Does that not indicate  
15 some illness on the part of the individual?

16 DR. ROEMMELE: Yes sir. If I might  
17 interrupt, this same man, we asked this man to be seen  
18 by a consultant of our choice when we knew he was seeing  
19 all these doctors. We didn't want to cancel him. We  
20 didn't want him going to all these doctors. He was  
21 getting medicine from all of them. It is a wonder he  
22 didn't kill himself. He was in a small area close to  
23 home and that is probably why he got home safely. This  
24 man was seen by a consultant, and also his union steward,  
25 who is the leader -- we told this union steward that  
26 this man was ill. He was a foreign chap. We didn't  
27 know whether he was understanding the letters we were  
28 writing to him. We directed this man to a consultant  
29 where he got good medical care, which we don't ordinarily  
30 do. We don't tell the doctors how to practise medicine.  
In this case this turned out very well, by the way,  
sir.

THE CHAIRMAN: There is a possible

MR. WALTON: Yes, May I cite one

example where a subscriber was seeing three general

practitioners in one day and doing that on several

successive days. We applied that,

THE CHAIRMAN: That would be evidence

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where he got good medical care, which we don't ordinarily

do. We don't tell the doctors how to practice medicine.

In this case this turned out very well, by the way.

THE CHAIRMAN: There is a possible



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3 situation, I don't know if it does occur under group  
4 coverage, but it was mentioned the employer must make  
5 one payment for the group. What would happen if the  
6 employer having undertaken to make payments for the  
7 group defaults in payment? Do all the beneficiaries,  
8 all the employees in that group, are they cut off if  
9 the premium is not paid by the employer?

10 MR. WALPOLE: We provide to those  
11 particular individuals in that unfortunate instance where  
12 their coverage as a group has not been paid, we do allow  
13 and extend to them the privilege of a pay-direct  
14 agreement.

15 THE CHAIRMAN: How do they know? The  
16 employer is supposed to send the money in the first of  
17 the month or the 15th?

18 MR. WALPOLE: We advise them.

19 THE CHAIRMAN: If it hasn't come in  
20 the contract terminates, is that right, that is the  
21 wording of it?

22 MR. WALPOLE: May I amplify my answer  
23 just a little bit. We are not quite that rigid.

24 THE CHAIRMAN: You say in clause 25:  
25 Failure to pay the subscription rates applicable shall  
26 entitle the corporation to automatically terminate the  
27 provisions of the agreement and it is specifically  
28 declared that time shall be of the essence of the  
29 provision for payment of all subscription rates.

30 MR. WALPOLE: We bill as of certain  
dates.

THE CHAIRMAN: You bill ahead of time?







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4 MR.WALPOLE: That is correct, but we  
5 have never cancelled a group until they were at least  
6 two months in arrears, and, in the meantime they have  
7 received three letters from us. We even go further.

8 THE CHAIRMAN: You mean the group,  
9 the employer?

10 MR. WALPOLE: The employer, and then  
11 we also advise the employees concerned in that group  
12 that their employer has not been remitting to us moneys  
13 on their behalf. That usually gets action unless the  
14 firm is almost bankrupt, and it gets action then because  
15 we are informed we haven't been paid for several days.  
16 We then take action to allow these people, and we will  
17 extend time to them, to pick up their pay direct.

18 COMMISSIONER VAN WART: How do you  
19 handle temporary lay-off in your group?

20 MR. WALPOLE: That has been partially  
21 taken care of in negotiations between the employee and  
22 his employer. Most groups in our area who are covered  
23 by union agreements have a clause which states something  
24 like this: That the employer agrees to pay two months  
25 beyond the month in which lay-off takes place. Generally  
26 they are back to work by that time. If they are not  
27 he cancels and we let them continue on a pay-direct  
28 agreement.

29 COMMISSIONER VAN WART: You still  
30 keep them covered?

MR. WALPOLE: Yes.

COMMISSIONER VAN WART: How long will  
you keep them covered over the two months?



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MR. WALSH: That is correct, but we have never cancelled a group until they were at least two months in arrears, and, in the meantime they have received three letters from us. We even go further. THE CHAIRMAN: You mean the group.

the employees?

MR. WALSH: The employer, and then we also advise the employees concerned in that group that their employer has not been remitting to us money on their behalf. That usually gets action unless the firm is almost bankrupt, and it gets action then because we are informed we haven't been paid for several days. We then take action to advise these people, and we will extend time to them to pick up their pay direct.

COMMISSIONER VAN WART: How do you

handle temporary lay-off in your groups?

MR. WALSH: That has been partially taken care of in negotiations between the employer and his employees. Most groups in our area who are covered by union agreements have a clause which states something like this: That the employer agrees to pay two months beyond the month in which lay-off takes place. Generally they are back to work by that time. If they are not he continues and we let them continue on a day-to-day basis.

COMMISSIONER VAN WART: You mean

that they are covered?

MR. WALSH: Yes.

COMMISSIONER VAN WART: How long will

you keep them covered over the two months?





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4 MR. WALPOLE: They would be cancelled  
5 from the group as from the end of the two months. We  
6 would then contact that individual directly at his last  
7 known address and allow him the privilege of continuing  
8 on his own until such time as he is returned to group  
employment.

9 COMMISSIONER VAN WART: He would pay  
10 the premium in the meantime?

11 MR. WALPOLE: That is correct.

12 COMMISSIONER STRACHAN: What happens  
13 when a participant leaves the employ of the group or  
leaves the two municipalities involved?

14 MR. WALPOLE: If he leaves the group  
15 and remains in our area it poses no problem because we  
16 follow this set-up and mail him a notice to continue  
17 on pay-direct agreement. If he leaves the area through  
18 the inter-plan transfer agreement signed by the Trans  
19 Canada Medical Plans we offer to transfer him to any  
20 area in Canada where he will be given credit for the  
waiting period fulfilled on our plan.

21 COMMISSIONER STRACHAN: Could he  
22 be assured he will have the same coverage as your plan?

23 MR. WALPOLE: No. He must take the  
24 coverage in effect in the area to which he transfers.  
25 If, for example, the coverage is not as comprehensive  
26 in some respect as ours then he must take that because  
that is the only thing available to him.

27 COMMISSIONER STRACHAN: On page 8  
28 you state that dental services in injury are included.  
29 Does that mean dental services performed by medical men  
30





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Mr. WATSON: They would be cancelled from the group at the end of the two months. We would then contact that individual directly at his last known address and allow him the privilege of continuing on his own until such time as he is returned to group employment.

COMMISSIONER VAN WAT: He would pay the premium in the meantime?

Mr. WATSON: That is correct.

When a participant leaves the employ of the group or leaves the two municipalities involved?

Mr. WATSON: If he leaves the group and remains in our area it poses no problem because we follow this set-up and mail him a notice to continue on individual agreement. If he leaves the area through the inter-plan transfer agreement signed by the Trans Canada Medical Plans we offer to transfer him to any area in Canada where he will be given credit for the waiting period fulfilled on our plan.

COMMISSIONER STEWART: Could he be assigned to have the same coverage as your plan?

Mr. WATSON: No. He must take the coverage in effect in the area to which he transfers. For example, the coverage is not as comprehensive in some respect as ours then he must take that because that is the only thing available to him.

COMMISSIONER STEWART: On page 2 you state that dental services in injury are included. Does that mean dental services performed by medical persons?



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3 or by dentists?

4 MR. WALPOLE: Dentists.

5 COMMISSIONER STRACHAN: By a dentist,  
6 and he doesn't have to be a participant?

7 MR. WALPOLE: I would draw your  
8 attention to the fact this is being underwritten through  
9 Physicians' Services Incorporated. We will pay in our  
10 area, but they underwrite it through P.S.I. It is  
11 extended health benefits.

12 COMMISSIONER VAN WART: If an employee  
13 dies does the widow and the family receive the two months'  
14 benefit following the death?

15 MR. WALPOLE: Well, that is entirely  
16 dependent, of course, on the agreement between the union  
17 and the employer. As far as we are concerned we allow  
18 those dependents and the widow to continue their  
19 coverage on a pay-direct agreement if they are taken  
20 off group. We will not see them without coverage. There  
21 is only one time we will, and that is we must receive  
22 premiums.

23 COMMISSIONER VAN WART: You don't  
24 give them the two months like you do in the lay-off?

25 MR. WALPOLE: May I qualify that  
26 point: We don't give them two months. We receive  
27 premiums for those two months from the employer.

28 COMMISSIONER VAN WART: After the  
29 lay-off. I had the idea it was collected before the  
30 lay-off.

MR. WALPOLE: No.

COMMISSIONER VAN WART: That is after  
the lay-off. I see.







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3 THE CHAIRMAN: On page 7 this question  
4 of the indigent, the indigent and the marginal income  
5 group, you say as a statement of policy to which almost  
6 everyone will agree these people must have medical care.  
7 I would even question the word almost. It becomes a  
8 question of how best to finance their medical care.  
9 You go on to say it is the intelligent and economical  
10 use of the tax dollar. What is the mechanism that you  
11 see for the subsidy by the State to take care of the  
12 indigent and the marginal income group?

13 MR. WALPOLE: As we see it the closer  
14 you get the more intelligent answer you are going to  
15 get to that particular problem. Rather than working at  
16 arm's length we feel if the municipality were to pay  
17 that would perhaps be best, and then, of course, you  
18 have to extend from there to the provincial field.  
19 We feel the closer you get to the problem areas the  
20 better that will be. Our first suggestion is the tax  
21 dollar of the municipality and failing that the tax  
22 dollar of the province.

23 COMMISSIONER McCUTCHEON: Would you  
24 think of the scheme that operates in public assistance  
25 generally whereby the municipality makes the disbursement  
26 and collects it back from the provincial and federal  
27 government on an agreed sharing basis. From what you  
28 have said you still feel it would be most efficient for  
29 the municipality to make the payment?

30 MR. WALPOLE: Yes, because they are  
acquainted with the local condition.

COMMISSIONER McCUTCHEON: You come as





THE CHAIRMAN: In page 7 to a question

of the industry, the intelligent and the marginal income group, you say as a statement of policy to which answer everyone will answer these people must have medical care. I would even question the word almost. It becomes a question of how best to finance their medical care. You go on to say it is the intelligent and educational use of the tax dollar. What is the mechanism that you see for the subsidy by the state to take care of the intelligent and the marginal income group?

MR. WALSH: As we see it the answer

you get the more intelligent answer you are going to get to that particular problem. Rather than working at a level where we feel the municipality were to pay that would perhaps be best, and then, of course, you have to extend from there to the provincial field. We feel the closer you get to the problem areas the answer that will be, our first suggestion is the tax dollar of the municipality and failing that the tax dollar of the province.

CHAIRMAN: Would you

think of the scheme that operates in public assistance and whereby the municipality makes the assessment and collects it back from the provincial and federal government on an shared sharing basis. From what you have said you still feel it would be most efficient for the municipality to make the payment?

MR. WALSH: Yes, because they are

confronted with the local condition.

CHAIRMAN: Would you



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close as possible to this rather Utopian idea that there is intelligent and economic use of tax funds.

THE CHAIRMAN: What of the indigent in the Windsor area. Naturally they are not able to pay premiums. Is there any provision now for subsidization of premiums by anyone?

MR. WALPOLE: Do I interpret your question --?

THE CHAIRMAN: Not by employers.

MR. WALPOLE: I am not quite sure that I follow you there.

THE CHAIRMAN: When you get somebody who cannot afford to pay a premium and wants coverage, can he get it, an individual?

MR. WALPOLE: Well, it is entirely dependent on the fact that we receive the premium. Now, as far as any municipality .....

THE CHAIRMAN: Yes, all right. I assume you are accepting here that there should be some extension of the principles for those who cannot pay and you say somebody -- the tax dollar should be used to pay the premium for them?

MR. WALPOLE: Yes.

THE CHAIRMAN: Is there anything like that being done now in Windsor?

MR. WALPOLE: No.

THE CHAIRMAN: I suppose the real indigent is looked after by the Welfare Department?

MR. WALPOLE: That is true.

THE CHAIRMAN: We come to the marginal

those are possible to raise rather than to raise them  
is to raise them and economic use of tax funds.

THE CHAIRMAN: What is the law, and

in the United States, including the new and old  
pay programs, is there any provision now for subsidiza-  
tion of business by anyone?

MR. WATSON: Do I understand you

concerned with

THE CHAIRMAN: That is a question.

MR. WATSON: I am not quite sure what

you mean by that.

THE CHAIRMAN: When you get some one

who cannot afford to pay a premium for health insurance,

and he gets it, an individual

MR. WATSON: Well, it is entirely

dependent on the fact that we receive the premium. Now,

as far as any responsibility....

THE CHAIRMAN: Yes, all right, I

assume you are suggesting here that there should be some

extension of the principles for those who cannot pay

and you say somebody -- the tax dollar should be used to

pay the premium for them?

MR. WATSON: Is there any thing like

that done now in any State?

MR. WATSON: Yes.

THE CHAIRMAN: I suppose the most

important is looked after by the health department?

MR. WATSON: That is true.

THE CHAIRMAN: Well, we are to the end of the



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4 group, people who support their day-to-day expenses but  
5 haven't the money to pay an insurance premium. Do you  
6 accept that they should have help from the State?

7 MR. WALPOLE: Yes.

8 THE CHAIRMAN: How would you go about  
9 it? You say the municipality should be the institution  
10 to make the payment. I think you went that far, did  
11 you not?

12 MR. WALPOLE: Yes.

13 THE CHAIRMAN: Have you any suggestion  
14 to make as to how the municipality will identify those  
15 for whom it should make payment in the marginal income  
16 group? For the indigent we know them because we are  
17 taking care of them now.

18 DR. ROEMMELE: Mr. Chairman, we were  
19 afraid you were going to ask this question when we  
20 prepared the brief. We didn't put it in because we  
21 didn't know the answer. We thought of a means test,  
22 and then we thought you would ask what means test. We  
23 don't know the answer there either. As you stated  
24 earlier we know the indigents. They come in with medical  
25 relief cards or the old age pensioners. Many of these  
26 people now, I am afraid, are looked after as bad debts  
27 by the doctors in the area.

28 THE CHAIRMAN: That is in this marginal  
29 group?

30 DR. ROEMMELE: Yes. This would be  
something that would be most difficult to define, but  
someone would have to set up an organization, I presume  
to do a means test on these people.





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4 THE CHAIRMAN: Now it has been said  
5 that the means test is degrading, demoralizing and this,  
6 that, and the other thing. Is that a valid statement  
7 in your experience, if you have any experience in that  
8 regard?

9 DR. ROEMMELE: The only experience I  
10 have is my own patients and in this I know people do  
11 come in with old age pensions, under 70 and over 65  
12 and they are with means test, they are eligible for  
13 their medical coverage and many of these I know could  
14 pay it themselves if -- not many. I shouldn't say that,  
15 but some, by disbursing their estate among their  
16 relatives which, I find, sometimes is a dangerous pro-  
17 cedure because sometimes the relatives then divorce  
18 themselves from father and mother but occasionally you  
19 see the odd person you think should be paying their own  
20 way and isn't.

21 Now, I don't think this is something  
22 that is done too often but it is done occasionally and  
23 I presume it could be done in this case.

24 THE CHAIRMAN: That is not what I  
25 am talking about, and if I gave you that impression I  
26 did not state my position clearly. I am talking about  
27 the fact of having to have some kind of an examination,  
28 which you might call a means test, to identify those  
29 properly entitled to be helped. Do those who might  
30 come within that category resent being examined in this  
way? Having their affairs examined in this way?

MR. WALPOLE: May I express a personal  
opinion?







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THE CHAIRMAN: Yes.

MR. WALPOLE: Not to be construed as that of Windsor Medical Service. I submit to an examination when I apply for a driver's licence. I submit to an examination when I apply for certain types of insurance. I submit to many different types of examination. None of these have I personally ever found embarrassing. Now if I am asking for something, I don't see why I should object to the facts being revealed.

THE CHAIRMAN: But if you are asking for something because of some inadequacy in yourself. That is, your inability to provide for your family; to expose your inadequacy have you found that that is resented?

COMMISSIONER BALTZAN: Isn't the exact opposite obtained? That so many people will come in daily and say I just haven't got the means to do this. I haven't got the money to provide for that. I can't buy drugs. I can't pay the bill. Is that not exposing themselves? Rather than applying the means test, they are supplying you with the information. The only other thing following upon that would be to prove that they don't have enough money. Someone, if I understand, asked about the humiliating factor. The degrading requirement of expressing themselves. Sometimes this is done or isn't it often done on a voluntary basis? I mean they say so themselves. People say that to doctors. People say that to such non-profit agencies as yourself.

THE CHAIRMAN: If I may put it very crudely, for the sake of just seeing if you have any





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THE CHAIRMAN: Yes.

MR. WATSON: Not to be concerned as

that of minor medical services, I submit to you

examination when I apply for a driver's license.

submit to an examination when I apply for certain types

of insurance. I submit to pay the cost of

examination. None of these have I personally ever found

embarrassing. Now if I am asking for something, I don't

see why I should object to the facts being revealed.

THE CHAIRMAN: But if you are asking

for something because of some interference in yourself.

That is, your inability to provide for your family; to

expose your inadequacy have you found that that is

needed?

COMMISSIONER BALLMAN: Isn't the exact

opposite obtained? That so many people will come in daily

and say I just haven't got the means to do this. I

haven't got the money to provide for that. I can't buy

clothes. I can't pay the bill. Is that not exposing them-

selves? Rather than applying the means test, they are

supplying you with the information. The only other thing

following upon that would be to prove that they don't

have enough money. Suppose, if I understand, asked about

the humiliating factor. The degrading requirement of

expressing themselves. Sometimes this is done or isn't

it often done on a voluntary basis? I mean they say so

themselves. People say that to doctors. People say that

to non-profit agencies as yourself.

THE CHAIRMAN: If I may put it very

clearly, for the sake of just seeing if you have any



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4 reaction. If you haven't, it is quite all right. We  
5 are now going to embark upon a program of health service.  
6 Those who can pay, just go ahead and pay. Those who  
7 are on social aid, they have no problem. Their premiums  
8 will be paid for them by the Welfare Department. We  
9 have this group in between that are not on social aid  
10 but who cannot pay. So the program is going into force  
11 on the first of June. What do we do? Put an ad in the  
12 paper and say "All those who cannot pay will queue up  
13 at the Royal York Hotel on the morning of the 30th of  
14 May?", because you are saying here that the State should  
15 pay that premium for them are you not?

16 MR. WALPOLE: I don't think, in my  
17 experience, today we have the same reticence on the  
18 part of an individual to admit to the fact that he is  
19 financially embarrassed, particularly if he thinks he  
20 is going to get something for nothing.

21 I think most individuals are ready  
22 to admit at that time. Therefore, it seems to me that  
23 this question resolves itself around just that very  
24 principle within the individual: Is he ready to admit  
25 that? I think most people are where they see it is  
26 going to benefit them in the long run.

27 THE CHAIRMAN: Thank you.

28 COMMISSIONER FIRESTONE: Mr. Walpole  
29 we were talking about group plans. You say in paragraph  
30 20 on page 4 that group coverage is available to groups  
of five or more, and then you say that there is a certain  
proportion of people in the group that must be covered  
and where there are over 14 employees you say 75% must







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4 enroll. Now how does this system work in practice?  
5 A firm comes to you and says we have 20 employees. We  
6 want to have group coverage. What do you do? Do you  
7 say to them out of 20, 15 must be subscribers? Is that  
8 correct?

9 MR. WALPOLE: That is true.

10 COMMISSIONER FIRESTONE: Well if the  
11 business firm can only find that 12 of these employees  
12 are willing to enter, they cannot be covered. Is that  
13 correct?

14 MR. WALPOLE: That is right.

15 COMMISSIONER FIRESTONE: Now if the  
16 majority of the employees, being 12, would like to be  
17 covered what happens in this particular case? Is there  
18 any compulsion. Hit the fellow over the head to join?  
19 How does it work in practice?

20 MR. WALPOLE: They have no problem  
21 Commissioner. If we have 12 there and they do not meet  
22 group requirements, we have a non-group and they are  
23 not denied coverage. It is there for them. The same  
24 coverage. It's a little more expensive, I admit, but  
25 the coverage, nevertheless, is there available to them.  
26 No one in the Counties of Essex or Kent as of today is  
27 denied coverage on any basis.

28 COMMISSIONER STRACHAN: How much more  
29 expensive? What is the ratio?

30 MR. WALPOLE: Let's talk about the  
family man with wife, two or more children. In the  
group he pays \$9.50. Non-group \$10.00.

COMMISSIONER FIRESTONE: Well now, to







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4 continue with this case, let's say the firm succeeds  
5 in getting 15 employees. The group is covered and one  
6 employee leaves. They have now only 14 and the new  
7 employee comes in and he doesn't want to be covered.  
8 They are down to 14 out of the 20 but they were 15 when  
9 they started. What would you do?

10 MR. WALPOLE: We would let that condi-  
11 tion persist for at least six months.

12 COMMISSIONER FIRESTONE: What has  
13 been the practice among the employers in your area? Do  
14 they require new employees joining the firm to be  
15 covered under the plan?

16 MR. WALPOLE: Most employers. It is  
17 pretty well a condition of employment.

18 COMMISSIONER FIRESTONE: This is a  
19 condition of employment to belong to the plan and to  
20 pay the premium?

21 MR. WALPOLE: Let me reverse that and  
22 say that the employer is obligated to pay a premium  
23 for that particular individual. Now if he conscientiously  
24 objects to being covered by Windsor Medical Service, then  
25 that is something different again but the employer,  
26 according to his union agreement, agrees to pay the  
27 premium of Windsor Medical for each and every one of  
28 his employees in the bargaining unit.

29 COMMISSIONER FIRESTONE: Therefore,  
30 if a new employee joins he is compelled to join as well?

MR. WALPOLE: That is right.

COMMISSIONER FIRESTONE: Simply  
because there is this contract in existence between the





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4 employer and his union, and the employer and the  
5 Windsor Medical Service?

6 MR. WALPOLE: Well, may I just  
7 clarify that last?

8 COMMISSIONER FIRESTONE: Could you  
9 explain it to me? I would like you to explain it.

10 MR. WALPOLE: This is not a condition  
11 of Windsor Medical Service. Windsor Medical Service  
12 does not enter into this whatsoever. That is strictly  
13 between the employee and the employer, or the employer  
14 and the negotiating body; the union representing the  
15 employees.

16 COMMISSIONER FIRESTONE: But you have  
17 a requirement of 75% coverage?

18 MR. WALPOLE: That is right.

19 COMMISSIONER FIRESTONE: You give them  
20 six months' grace if they fall below that?

21 MR. WALPOLE: That is right.

22 COMMISSIONER FIRESTONE: That is  
23 part of your contract?

24 MR. WALPOLE: Right.

25 COMMISSIONER FIRESTONE: With the  
26 employer?

27 MR. WALPOLE: Right.

28 COMMISSIONER FIRESTONE: And, therefore,  
29 if he were to live up to the contract he must have some  
30 ways and means of putting it into effect.

MR. WALPOLE: That is true.

COMMISSIONER FIRESTONE: The way to  
put it into effect is to compel a new employee to join  
the plan, so that can effect the group plan as far as







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4 the employees are concerned. His participation is  
5 compulsory in the group plan?

6 MR. WALPOLE: Yes, it is compulsory.

7 COMMISSIONER McCUTCHEON: It's the  
8 union that compels him.

9 MR. WALPOLE: The point is raised here  
10 that we are talking primarily here of where a negotiated  
11 agreement is in effect.

12 COMMISSIONER FIRESTONE: Correct.

13 COMMISSIONER BALTZAN: Is that a  
14 compulsion or is that just a term of condition for the  
15 employment by that employer?

16 MR. WALPOLE: It is a term of condition.

17 COMMISSIONER BALTZAN: Is that a term,  
18 say, comparative to the number of working hours, et  
19 cetera, et cetera?

20 MR. WALPOLE: I am sorry, I didn't  
21 hear the last.

22 COMMISSIONER BALTZAN: There is a  
23 compulsory element or is it, not just one other term for  
24 employment or terms of employment?

25 MR. WALPOLE: It's terms of employment.

26 COMMISSIONER BALTZAN: Rather than  
27 compulsion?

28 MR. WALPOLE: Yes.

29 COMMISSIONER FIRESTONE: Well now sir---

30 MR. FUERTH: That is not 100%. All  
employers do not have such an arrangement.

COMMISSIONER FIRESTONE: Mr. Walpole,  
you have had some other questions from other Commissioners



The first thing we do is to establish the conditions

concerning the terms of the plan.

Now, what is the first condition?

It is that the plan

must be approved by the

The point is that we

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Firstly,

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4 and you have had dealt with them. If I may repeat my  
5 understanding, and please correct me if my understanding  
6 did not go to the point. My understanding is that if  
7 a company has entered into a group contract that it  
8 requires 75% employment coverage, they have fulfilled  
9 that requirement; that if they wish to maintain this  
10 contract in good order, they have to provide 75% of  
11 their employees to belong to the plan, and presumably,  
12 I understood in many cases there are also contracts  
13 in existence between the management and the union which  
14 require obligatory participation in this medical care  
15 plan, sponsored by your Association. Therefore, if  
16 new employees enter into the employment of the company,  
17 they are obligated to participate in that plan as part  
18 of the terms of their contract. Is that correct?

17 MR. WALPOLE: They are obligated by  
18 the terms of the agreement signed between the employer  
19 and the employees or the negotiating committee representing  
20 those employees but I want to make it abundantly clear  
21 there is no compulsion on the part of Windsor Medical  
22 Service.

22 THE CHAIRMAN: A correct way of  
23 expressing it is that an employee coming into the  
24 employment of such a concern has the added benefit,  
25 without cost to him, of the service.

26 MR. WALPOLE: Right.

27 THE CHAIRMAN: Because it's the  
28 employer who has a contract to provide it as part of  
29 his contract with the union?





... you have had contact with them. If I have not, my  
understanding, and please correct me if I am wrong, is  
that not so to the point, the understanding is that if  
a company has entered into a group contract that it  
represents the employees covered, they have accepted  
that as settlement; that is, they have accepted the fact  
that in good faith, they have accepted the fact that  
their employees are bound to the plan, and presumably,  
I understand, in many cases there are also contracts  
in existence between the management and the union which  
regarding obligatory participation in the medical care  
plan, sponsored by your association. Therefore, if  
new employees enter into the employment of the company,  
they are obligated to participate in that plan as part  
of the terms of their contract. Is that correct?  
... They are obligated by  
the terms of the management contract between the employer  
and the employees or the negotiating committee representing  
those employees but I want to make it abundantly clear  
there is no compulsion on the part of Lincoln Medical

... A correct way of  
expressing it is that an employee coming into the  
employment of such a concern has the added benefit,  
without cost to him, of the service.

... Because it's  
... a contract to provide it as part of  
the work with the company.



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Walpole 9083

COMMISSIONER FIRESTONE: Does the employee make a contribution to the plan or is it 100% paid by the employer?

MR. WALPOLE: It is entirely a negotiated item.

COMMISSIONER FIRESTONE: Are you familiar with some of these contracts?

MR. WALPOLE: Yes. In some instances it is 100% paid by the employer and in others it is shared at varying degrees of contribution by the employee and the employer.

COMMISSIONER FIRESTONE: From your experience with the majority of contracts involving a number of employees would it be on a sharing basis or a 100% employer basis?

MR. WALPOLE: I would say at least 50% were on a shared basis --- where there is employee participation at least 50% would be on that basis.

COMMISSIONER FIRESTONE: You made it quite clear there is no obligatory requirement as far as the employees joining the Windsor Medical Services contract, but there is an obligation on the part of the employer to retain a 75% ratio and that is the contractual obligation between the employer and Windsor Medical Services?

MR. WALPOLE: Yes.

COMMISSIONER FIRESTONE: And, therefore, if the employer therefore requires the employee to join, this is part of the fulfillment of the obligation which he has with W.M.S., is that correct?



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employee make a contribution to the plan or is it 100% paid by the employer?

MR. WATKINS: It is entirely a negotiated

CONTRACTOR: And you said that

with some of these contracts?

it is 100% paid by the employer and in others it is shared or varying degrees of contribution by the employer and the employer.

agreement with the majority of contracts involving a number of employees would it be on a sharing basis or a 100% employer basis?

MR. WATKINS: I would say at least 50% were on a shared basis -- where there is employee contribution at least 50% would be on that basis.

other than that there is no obligatory requirement as far as the employees within the Windsor Medical Services contract, but there is an obligation on the part of the employer to retain a 50% ratio and that is the contractual obligation between the employer and Windsor Medical Services.

MR. WATKINS: Yes.

the employer therefore requires the employer to join that is part of the fulfillment of the obligation which is the 50% ratio, is that correct?



Walpole 9084

THE CHAIRMAN: If you do not agree with the semantics of it, we just have to disagree.

MR. WALPOLE: Well, if you wished to maintain the coverage provided through Windsor Medical Services, a contract is a contract; if you do not live up to the contract and the contract ceases to be honoured by him then we in turn will cease to honour it.

COMMISSIONER FIRESTONE: May I now turn to Paragraph 25 and 26 on page 6 in which you are referring to a number of employees continuing with the Windsor Medical Services contract even though they were offered contracts under the Civil Services provisions. Do I understand from these two paragraphs, 25 and 26, that the number of people would have dual coverage?

MR. WALPOLE: That is true.

COMMISSIONER FIRESTONE: Are they then permitted to collect twice when medical bills are presented?

MR. WALPOLE: May I answer the first part of your question?

COMMISSIONER FIRESTONE: Please do.

MR. WALPOLE: As far as we are concerned they may have dual coverage. Now, what the other carrier has written into his agreement, I do not know, he may preclude that, but as far as we are concerned, that is a choice which the subscriber in this case could have made or could not have made, to carry both coverages.

COMMISSIONER FIRESTONE: Do I understand from that that you would honour and pay the bills whether he has dual coverage or not?

MR. WALPOLE: That is true.





THE CHAIRMAN: If you don't mind,

with the assistance of it, we have to go on.

THE WITNESS: Well, if you would like to

maintain the record, I think I should like to

believe, a contract is a contract; if you don't have

up to a contract, the contract seems to be handled

by either of the two sides to a contract.

COMMISSIONER FINESTON: May I now

turn to Paragraph 13 and 14 on page 6 in which you are

referring to a number of employees continuing with the

Industrial National Services contract even though they were

offered contracts under the Civil Service provisions. Do

I understand from these two paragraphs, 13 and 14, that

the number of people would have been covered?

THE WITNESS: That is true.

COMMISSIONER FINESTON: Are they then

permitted to collect twice their medical bills and present?

THE WITNESS: May I answer the first

part of your question?

COMMISSIONER FINESTON: Please do.

THE WITNESS: As far as the contract

they may have been covered. Now, what the other contract

was taken into his agreement, I do not know. He may

have been told, but as far as we are concerned, that is a

matter which was handled in this case and it has been

on which I have made, to say the least, a

COMMISSIONER FINESTON: Do you have

any other questions for me today?

THE WITNESS: No, thank you.

THE CHAIRMAN: All right.



Walpole

9085

COMMISSIONER FIRESTONE: And if he can collect it from the other carrier that is his business?

MR. WALPOLE: That is right.

COMMISSIONER FIRESTONE: May I now turn to Paragraph 36 on Pages 7 and 8. Some questions with respect to these paragraphs have been asked by other Commissioners and I wondered whether you would be of a little help to me on the practical implementation of some of the ideas which you seem to have in mind in this paragraph. As I understood from you a little earlier your Association is in favour of having the premium for the indigent and the medically indigent paid by the State, is that correct?

MR. WALPOLE: Yes.

COMMISSIONER FIRESTONE: Trying to visualize a practical scheme and an administrative arrangement in which this sort of idea could be put to work, could you visualize an arrangement whereby the State, and I presume in this case it is the Province of Ontario, with or without Federal participation would make such payments, say, for people living in the Windsor area to the Windsor Medical Services? Is this the way you would visualize such a scheme to work?

MR. WALPOLE: As we had indicated earlier, we say, first, we would suggest the municipality take this on and failing that then it is the Provincial field of taxation.

COMMISSIONER FIRESTONE: I take it when you are referring to the municipality and subsequently to the Province you are thinking in terms of where the



Page 10

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who is from the other side of the water.

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Walpole 9086

money is coming from, am I right?

MR. WALPOLE: That is right.

COMMISSIONER FIRESTONE: I am talking about something else, I am talking about the administration of such a plan. In other words, you have an organization, you are accustomed to collecting premiums, you are accustomed to looking at bills, you are accustomed to honouring those bills and they are paid to the participating physicians. Now, you have the mechanism and experience so the question arises if the Government of Ontario either directly or in cooperation with the municipalities were to extend that plan to cover the indigent which are already covered plus the medically indigent which is the marginal group the Chairman was talking about, what type of administration could be put into effect to make this plan work. My question is, could the Windsor Medical Services administer this plan for the indigent and medically indigent within the Windsor area?

MR. WALPOLE: I would say we could.

COMMISSIONER FIRESTONE: Would you feel that such a method of operation using the experience that you have built up and the administrative machinery, would be an efficient way of doing it rather than setting up new agencies or boards or commissions or having the municipalities doing it on their own individually?

MR. WALPOLE: Yes.

COMMISSIONER FIRESTONE: Did you say a little earlier that you were selling some policies for P.S.I.?





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MR. WALTON: I would say the...

MR. WALTON: I would say the...

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MR. WALPOLE: Extended health benefits only.

COMMISSIONER FIRESTONE: Could you explain this to us a little how you cooperate with P.S.I.?

MR. WALPOLE: Yes. In relation to extended health benefits the only thing, our agreement is to this effect that we will bill for subscribers in our area who require extended health benefit coverage and we will sell the P.S.I. plan, bill for it and remit the premiums to P.S.I.

COMMISSIONER FIRESTONE: What is the reason as to why you are acting as a sales agent? Are you acting really as a sales agent? Maybe I did not quite understand the arrangement. How does it really work?

MR. WALPOLE: I might say this, in our area, as you can appreciate, we have a very limited population. In other words, we have 68% of our population now covered and even if we had it all, it would only embrace some 330,000 people. We feel in this particular area the number of contracts which would be sold by us would not be actuarially feasible for us to get into that sort of program. Therefore, we have gone to P.S.I. to underwrite those.

COMMISSIONER FIRESTONE: Are there perhaps certain advantages for various of these voluntary non-profit medical insurance groups to work more closely together? Is there not a certain advantage to be derived from spreading the risk and perhaps other advantages? Could one not go somewhat further than you have gone so far in order to provide the comprehensive medical care



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Walpole 9088

plan for the Province of Ontario?

MR. WALPOLE: I think it is an accepted insurance principle that the greater area over which you spread your risk better off you are.

COMMISSIONER McCUTCHEON: But there is an optimum number of risks beyond which you do not get any additional benefit?

MR. WALPOLE: That is right, I would agree with that.

COMMISSIONER McCUTCHEON: That optimum number will depend on the type of insurance business you are doing?

MR. WALPOLE: Right.

COMMISSIONER FIRESTONE: This point has really not been reached in your area, has it, this so-called optimum?

THE CHAIRMAN: It has not been reached at all, he has not touched it.

MR. WALPOLE: Are you referring now to extended health benefits only?

THE CHAIRMAN: That is what we were talking about, if I understand it.

MR. WALPOLE: I would certainly say it has not been reached in our area whether it would be feasible for us to even consider writing this.

COMMISSIONER FIRESTONE: Exactly, that is why I did not feel that this question of optimum in the context we were discussing it had any bearing.

THE CHAIRMAN: If I may say so, I think it did. I think the question is relevant because you had







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translated yourself from Windsor to the Province of Ontario and Mr. McCutcheon's suggestion was perhaps you did not need the whole Province of Ontario, that you could reach the optimum without taking in the whole territorial area of Ontario.

COMMISSIONER McCUTCHEON: I think what Mr. Walpole would say, and correct me if this is not a statement of your views, but he has reached the optimum, he has the optimum number now in his group and direct pay and individual coverage which is exactly what P.S.I. said this morning. He has not the optimum for this so-called extended health benefit.

MR. WALPOLE: That is true.

COMMISSIONER McCUTCHEON: In other words, the optimum varies depending upon the type of business you are doing?

COMMISSIONER FIRESTONE: To come back to the basic question that I am after is to find out whether you would feel that increased cooperation with some of these similar groups with a larger group like P.S.I. could produce increased benefits to the insured population of the Province of Ontario.

MR. WALPOLE: Well, I have, in answer to that, we have some reservations on a positive answer to that. We feel that there are certain advantages which perhaps might offset some of the economic advantages gained by such a program as you envisage. We feel that if a subscriber, if a participating physician is able to pick up the phone or walk into an office, into our office and say, "Here is my problem, what can I do about it?"



did not need any whole number of 100,000, that you  
could reach the optimum without leaving in the whole  
numbered area of 100,000.

Q. Now, Mr. W. A. I think you

Mr. W. A. I think you, and I think as it is a lot of  
work of your views, but he has reached the optimum, he  
has the optimum number now in his group, and I think you  
in which group work is exactly what I said in  
morning. He has not the optimum for this some-  
extension in his hands.

Q. Now, Mr. W. A. I think you

Q. Now, Mr. W. A. I think you

work, the optimum number depending upon the type of  
business you are doing.

Q. Now, Mr. W. A. I think you

to the fact, I am afraid in the fact  
whether we could get that increased productivity  
one of these similar groups with a larger group life  
could be done, I think, I think, I think, I think  
some of the things that I think I think.

Q. Now, Mr. W. A. I think you

to that. We feel that there are certain advantages of  
business with that one of the things that I think

based on some of the things that you have said, we think  
it is a lot of things that I think I think

the things that I think I think, I think, I think  
and I think, I think, I think, I think, I think



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we feel we are accomplishing something that cannot be accomplished at the end of your arm. So, even though you might accomplish some economic gains, I think you would lose something in your public relations and in service to the public.

answer. Sometimes COMMISSIONER FIRESTONE: You said earlier that you feel that your organization could usefully cooperate with the Provincial Government and/or municipalities in administering such a scheme which would look after the indigent and the medically indigent. You see, the problem that the Province of Ontario would be facing if such a plan were to go into operation would be, who it might approach to look after this type of administration. As we understand, there is something like close to forty voluntary non-profit organizations in operation and the choice the Government would have is either to make these funds available for the premium payment for the indigent and medically indigent to either one of these organizations or it could select one carrier or say to these forty carriers "Perhaps you fellows could get together and look after the administration of such a program." The difficulty the Government faces, it has close to forty organizations to deal with when they want to implement such a program and it is much more efficient to deal with one. How would you visualize a Government to go about this if it wishes to use the experience that has been built up for many years in administering such plans in the Province of Ontario?

MR. WALPOLE: Of course, I being the manager, I have to rely on my Board for my policy direction.







Walpole 9091

I think you are posing a question which I could not answer as to what the position of Windsor Medical Services would be if such a question were posed to them. I cannot answer that.

COMMISSIONER FIRESTONE: It is a fair answer. Sometimes one does not have the answer and there are a lot of questions we do not have the answers to, but at least we are trying to get them. Can you visualize, being a manager and a man of experience, if your Board came to you and said, "This is the problem, the Provincial Government plus the Federal Government is willing to participate in such a plan" and they come to you and say, "How could we work this out with the other groups in the Province of Ontario", could you visualize, for instance, that an association would be formed in which all groups would participate and participate both in the management and in the arrangement with the individual groups so the Government of Ontario would be with one group of these medically sponsored groups rather than with forty? You realize that the alternative is they would have to rely on municipalities of which there are many hundreds to set up its own commission. There are all kinds of alternatives, but if one wants to use the body of knowledge built up over twenty-five years or more they have to come to the people in the field, so how could such a thing be developed?



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MR. WALPOLE: In answering your question may I ask one more for clarification of my own thinking? Would each of these 40 different units remain as an autonomous unit in this so-called program?

COMMISSIONER FIRESTONE: Well, one would come to these 40 groups and say: "The Government is looking for one agency or one group that could administer the program. How could these 40 groups work within the organization?" And the question would be thrown to the groups in existence at the moment and they would be asked: "How do you think you could work, retaining your own operation but co-operating in this overall plan?"

MR. WALPOLE: My only answer would be to point to the organization known as Trans-Canada Medical Plans in which we have a similar situation as you portray except it is on a Dominion-wide basis, and we have worked out programs whereby we are able to provide coverage for national employers and so on, and it seems to me that this could be fitted into a program built along similar lines.

COMMISSIONER FIRESTONE: In other words, you could visualize instead of having a trans-Canada plan you could visualize an Ontario plan?

MR. WALPOLE: Yes.

COMMISSIONER FIRESTONE: Is that along the lines?

MR. WALPOLE: Yes.

COMMISSIONER FIRESTONE: Would you feel if such a plan or organization were to be built up, would it be acceptable to the participating group who have on







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the Board of Directors, Board of Governors, whatever you want to call this plan, representatives of government, simply because government will make a major contribution?

COMMISSIONER McCUTCHEON: Why a major contribution?

COMMISSIONER FIRESTONE: Would you feel such a participation within such a Board would affect the voluntary character of your organization?

MR. WALPOLE: I can only answer that one way; I can only speak of our experience in our own organization, and we have always found our Directors have a very open mind on everything that will further the plan, and if this were put as a proposition to them I am sure it would be given due consideration. What the answer would be I don't know.

COMMISSIONER FIRESTONE: Now, Mr. Walpole, just in conclusion, I would like to read to you a quote from the Charter of Physicians' Services Incorporated in their paragraph D on page 1. This is not part of the quote; it is just the introduction. Purposes and objectives of the Physicians' Services Incorporated include: "to assist the Government in the Province of Ontario or any governmental or municipal authority upon request in strengthening the health services."

Does your Association have a similar provision in your Charter?

MR. WALPOLE: No. I might refer to the terms of our aims and objects of our Charter on page 2, paragraph 10:

"To arrange for the provision to others



the story of these men, and of the way they  
went to the front, and of the way they  
came back, and of the way they  
lived, and of the way they died.

It is a story of the men who  
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of any or all services required in the prevention, diagnosis or treatment of illness as recognized by legally qualified medical practitioners in the Province of Ontario on a non-profit, prepayment and voluntary basis; for the purposes aforesaid to establish reserves and administer the same; to encourage medical research and preventive medicine; to co-operate with organized medicine in the advancement of the standard of medical service; and to do all such other things as are incidental or conducive to the attainment of the above objects."

COMMISSIONER FIRESTONE: Would you consider, with the intimate knowledge of the objects of your Association, that in principle and not in specific terms, because you have read the full text of the objectives, that your Association would adopt the sort of objectives which the Physicians' Services Incorporated have included in their Charter, and those, if I may recall, are: "to assist the Government in the Province of Ontario or any governmental or municipal authority upon request in strengthening the health services."?

MR. WALPOLE: I would like either our President or Vice-President to answer that question, if they would.

COMMISSIONER FIRESTONE: By all means,







Durocher

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2  
3  
4 sir.

5 DR. DUROCHER: I think the terms  
6 mentioned in our Charter would cover it; that is a pretty  
7 broad statement, and I think that anything that would  
8 strengthen medical care Windsor Medical would be in  
9 favour of.

10 COMMISSIONER FIRESTONE: Including  
11 co-operation with the Province of Ontario and municipali-  
12 ties?

13 DR. DUROCHER: If it was deemed advisable  
14 they would be probably quite willing to co-operate.

15 COMMISSIONER FIRESTONE: Thank you very  
16 much. You have been very helpful.

17 COMMISSIONER STRACHAN: With your  
18 permission, Mr. Chairman, I would like to clarify one  
19 point regarding dental injuries. I have no doubt that  
20 refers to jaw fractures. Does it also include restorative  
21 work, where teeth have been lost?

22 DR. ROEMMELE: No.

23 COMMISSIONER STRACHAN: And it is the  
24 result of injuries?

25 MR. WALPOLE: I am informed that as a  
26 result of injury that would take care of that situation.

27 THE CHAIRMAN: Thank you very much, Mr.  
28 Walpole and gentlemen. We are going to continue at 2.15.  
29 Now, you are free to remain; this is not a dismissal in  
30 a sense. If you wish to participate further in any  
discussions that may take place during the afternoon, as  
you know, the day is devoted to the study of these prepaid  
medical programs.





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So we will now recess to 2.15 when we  
will proceed with the Co-operative Medical Services  
Federation submission.

MR. WALPOLE: Thank you very much, Mr.  
Chairman.

--- Luncheon Adjournment.





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on this date.

W. J. BARKER: Thank you very much, Mr.



--- On resuming at 2.15 p.m.

THE SECRETARY: Mr. Chairman, the first presentation this afternoon is the Co-operative Medical Services Federation of Ontario which will be known as Exhibit 244. Mr. McCoig will introduce his group to the Commission.

--- EXHIBIT NO. 244: Submission of the Co-operative Medical Services Federation of Ontario.

SUBMISSION OF THE CO-OPERATIVE MEDICAL SERVICES

FEDERATION OF ONTARIO

Appearances: Mr. E. Schofield  
Mr. W.G. McCoig  
Mr. R.P. Forshaw  
Mr. A. McLaughlin

THE CHAIRMAN: Mr. McCoig?

MR. McCOIG: Mr. Chairman, members of the Royal Commission: it is my privilege at the present time to introduce to you Mr. Arthur McLaughlin, on my extreme left, a farmer from Eastern Ontario; on my immediate left, Professor R.P. Forshaw from the Ontario Agricultural College; on my right, Mr. Ted Schofield, our Provincial Secretary, formerly with the Health Insurance Group and presently acting as our Provincial Secretary of the Co-operative Medical Services Federation of Ontario.

Myself, I spent the major part of my life on a farm. For the past eight years I have managed the Kent Co-operative Medical Services from Chatham, Ontario.



--- On April 2, 1944

The following is the report of the

first presentation of this report is the Co-operative  
Medical Services Association of which will be  
in the hands of Mr. McCall who introduces me  
to the Commission.

--- On April 10, 1944: Submission of the Co-operative  
Medical Services Association of

MEMORANDUM OF THE CO-OPERATIVE MEDICAL SERVICES ASSOCIATION

MEMORANDUM OF THE ASSOCIATION

Addressed to: Mr. A. McCall  
Mr. A. McCall  
Mr. A. McCall  
Mr. A. McCall

TO: CHAIRMAN: Mr. McCall

FROM: Mr. McCall, Chairman, member of

the Royal Commission: it is my privilege as the president

of the Association to present to you, Mr. Arthur McCall, on my

behalf, a letter from the Eastern Ontario, on my

behalf, a letter from the Ontario, on my behalf, a letter from the Ontario

Association of which I believe, on my behalf, a letter from the Ontario

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of the Co-operative Medical Services Association of

which, I believe, is the report of the

Association of which I believe, on my behalf, a letter from the Ontario

Association of which I believe, on my behalf, a letter from the Ontario



McCoig

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THE CHAIRMAN: You may sit down, Mr. McCoig.

MR. McCOIG: Thank you, Mr. Chairman, for making a nervous layman a little more at home.

Mr. Chairman and members of the Royal Commission, we come before you today representing the Co-operative Medical Services Federation of Ontario who are a co-ordinating body for some 29 member counties in Ontario.

These member counties are consumer groups and primarily self-employed. The co-operatives people link with rural people in our medical co-operative - but that is not entirely so, because we have two member counties that are quite large who have urban people on their membership.

The Co-operative Medical Services recommends to the member counties principles and policies, but there is nothing mandatory, whereas the member counties have to accept or implement. We merely recommend.

We finance the Federation by an assessment of the earned income from each county.

THE CHAIRMAN: That is all the Federation?

MR. McCOIG: Yes. We maintain an office and staff here in Weston. Our Federation is a member of the Group Health Association of America. It was referred to this morning, some of the members, H.I.P., I believe. We have a member on their Directorate, and on several occasions have had representatives speak to our annual meeting of their plans.

Our brief to you today is not long in





THE CHAIRMAN: You say sir, now, Mr.

Mr. Chairman.

top making a nervous system a little more a little more.

Chairman, we come before you today representing the Co-operative Medical Services Federation of Ontario who are a co-ordinating body for some 29 member counties in Ontario.

These member counties are concerned groups and primarily self-employed. The co-operatives people link with rural people in our medical co-operative - but that is not entirely so, because we have two member counties that are quite large who have urban people on their respective.

The Co-operative Medical Services Federation to the member counties principles and policies, but there is nothing satisfactory, whereas the member counties have to accept or incident, we merely recommend. We finance the Federation by an assessment of the earned income from each county.

THE CHAIRMAN: That is a fact. The Federation is a member and still have in London. The Co-operative Medical Services Federation of Ontario is a member of the Co-operative Medical Services Federation of Ontario. It is referred to this morning, some of the members, I believe, we have a number on rural lines, and on several occasions have had representatives speak to our annual meeting of their plans. Our brief to you today is not long in



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content, it has facts that I would like to present to you at this time by, with your permission, reading the brief as you have it before you.

Mr. Chairman, members of the Royal Commission:

1. The Directors and members of the Co-operative Medical Services Federation of Ontario wish to express their pleasure at the opportunity to appear before your Commission. The matter of health care for the people of Canada is a vital issue that concerns everyone.

2. Medical Co-operatives in Ontario came into operation because of a firmly held conviction that in the long run the soundest job could be done by the grouping together of those using medical care to work in conjunction with those providing the service to bring the benefits of the highest quality medical care to all who wished to join such a program. Our aims are in complete agreement with the World Health Organizations' definition of health, i.e. "the estate of complete physical, mental and social well being, not merely the absence of disease or infirmity."

3. Originally our program concentrated on hospitalization. Most of our efforts during the late 1940's and early 1950's were spent in finding funds to pay the rapidly rising costs of hospitalization. In the 1950's we enlarged to provide surgical coverage and more recently major medical and in-hospital medical because we have found that medical and related costs fall very unevenly on the average member. We have long recognized



...is not less than I wish like to present to  
you at this time, with your assistance, and I  
believe as you have in before you.

...and ...  
...and ...

1. The Directors and members of the  
Co-operative Medical Services Federation in Illinois wish  
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before your Commission. The matter of health care for  
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2. Medical Co-operatives in Illinois  
are not operationally a part of a health care organization  
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in a situation with those providing the service to bring  
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early 50's we began to provide a medical service and care  
in the home and hospital medical care.  
We have found that medical and hospital care is very  
expensive on the part of the patient. We have been negotiating





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that early detection and treatment of illness can do much to lessen morbidity and as funds became available programs of medical examinations were sponsored and paid for by our member co-operatives.

4. We have operated largely among self-employed persons, including farmers, and have brought the benefits of prepaid medical care to many who would otherwise have been unable to obtain low cost group coverage. Because of a knowledge of community health needs, Co-operatives have accepted as members those in the higher age brackets and many who would be uninsurable under other plans. This has provided a much needed service to the entire community. In addition, we have created an awareness of the need for and value of prepaid insurance and also of the importance of the programs of the Ontario Hospital Services Commission and the Workmen's Compensation Board. Since the inception of the Ontario Hospital Services Commission plan, all Federation members have acted as collector groups without remuneration, as a service to our members and the community, but because a Medical Co-operative has no source of funds other than premium income, and a small interest income from unearned premium, we would have to establish an agreed upon cost of operation to enable us to fully participate in any additional community service program.

5. We have among our members a number of employee groups who are well satisfied with the coverage offered but we find that we are unable to compete effectively in the industrial field against physician-sponsored plans which settle with participating practitioners





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additional community service program.

"We have among our members a number  
of employees groups who are well satisfied with the  
coverage which they are getting and we are anxious to continue  
activities in the industrial field against physical  
accidents which are well set up with participating organizations.



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on a percentage basis. We feel that your Commission should study the broad implications of this situation which has been termed by many as being unfair competition. An additional difficulty is that the published Ontario Medical Association Schedule of Fees is not rigidly held to by some practitioners and this makes impossible the development of any actuarially sound complete prepayment plan.

6. We recommend to your Commission the following:

(i) That in whatever program develops from your recommendations people interested in the field of health care, as well as professional people, should have a part in the development of the programs decided upon.

(ii) That each insurer be required to accept its share of sub-standard risks in the interest of universal coverage.

(iii) That, because good health care is coming to be recognized as the right of all Canadians, any plan must be mandatory to make it effective.

(iv) That provision be made within the plan for placing preventive care on the same basis as the care of actual illness. This we feel will not only improve the general health of the population but lower the overall cost by detecting many conditions in their initial stages and



on a percentage basis. It is not that your Commission should study the broad implications of this situation which has been termed by many as being unfair competition. An additional difficulty is that the sub-labeled Ontario Medical Association schedule of fees is not rightly borne by some practitioners and this makes impossible the development of any substantially sound complete programme

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(i) That in whatever program develops from your recommendations people interested in the field of health care, as well as professional people, should have a part in the development of the program

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(iii) That, because good health care is coming to be recognized as the right of all Canadians, any plan must be mandatory to be effective

(iv) That provision be made within the plan for the long preventive care on the same basis as the care of acute illness. This will not only improve the general health of the population but also the overall cost by decreasing many conditions in their earlier stages and





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enabling early and effective treatment.

(v) That, as social values are enhanced when a person has a definite stake in his own plan, there be developed a system of co-insurance which would work little or no hardship on anyone but would discourage over-use of the plan.

(vi) That any plan be financed partly by premium and that the premium be reduced at age 65, or in cases where financial need is proven. This provision would work less hardship on many who are in need or have limited means.

7. In conclusion we would like to assure this Commission that the Medical Co-operatives in Ontario stand ready at all times to assist in the development of any program that will materially improve the health and well-being of the members of our Co-operatives and of the citizenry as a whole.

Respectfully submitted on behalf of the  
Co-operative Medical Services Federation of Ontario.

THE CHAIRMAN: Thank you, Mr. McCoig.  
Now, as indicated this morning when you had an opportunity to listen to the other submissions and discussions which followed, have you anything that you would like to add now by way of explanation or to contribute to the discussion we had this morning?

MR. McCOIG: With your permission, Mr. Chairman, I will invite the other members here with me to



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add what they may have to add to this submission.

THE CHAIRMAN: Mr. Forshaw?

MR. FORSHAW: And as you know, I came to Ontario approximately 15 years ago.

THE CHAIRMAN: From Saskatchewan.

MR. FORSHAW: I was a member, and still am, of another medical co-operative. When I came here I became interested in the work in this province although I have another alternative available to me. I might say it has been very satisfying work, working with people who wanted to do something for themselves.

One of the points I should stress is that Medical Co-operatives have been uniquely successful in the rural areas and among self-employed people because of our system of operating.

First of all, to a certain extent, it is decentralized through directors drawn from the entire area served, and in many counties through group secretaries, so that we know personally and we live with a very high percentage of our members.

This has been very satisfying and at the same time it has kept us on our toes. On the other hand, it has made us very acutely aware of their needs and their problems because we live very close to them. We deal with them at short range rather than at arm's length, as someone stated this morning.

This is just a personal point. I, of course, go along with the points made in the brief. Numerically we are not large, but the Medical Co-operatives have served a segment of Ontario that is perhaps difficult



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THE CHAIRMAN: Mr. Tolson.

MR. TOLSON: And as you know, I came

to Central approximately 15 years ago.

THE CHAIRMAN: Thank you, Mr. Tolson.

MR. TOLSON: I was a member, and still

am, of another medical co-operative. When I came here

I became interested in the work in this province although

I have another alternative available to me. I might say

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the same time it has kept us on our feet. On the other

hand, it has made us very acutely aware of their needs

and their problems because we live very close to them.

We deal with them at about twice the rate of other

people, as someone stated this morning.

This is just a personal point. I, as

doctors, go along with the points made in the model.

Medically we are not large, but the Medical Co-operatives

have solved a segment of our problem that is perhaps difficult





Forshaw

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to reach by other plans, and the loss ratio has been low, and the loyalty to Medical Co-operatives is high.

I feel they have made a contribution and will continue to make a contribution.

THE CHAIRMAN: Anything else? Mr. McLaughlin?

MR. McLAUGHLIN: Mr. Chairman, I would back up Mr. Forshaw's claim that we have members that are partially uninsurable in any other type of insurance except co-operatives. They came to us, some of them over-age, uninsurable because of one condition or another, and we usually accept them.

While this makes it rather difficult for us to show a good sheet at the end of the year we think it is a wonderful satisfaction to cover these people and at no great loss to the organization. That is all I have at the moment.

THE CHAIRMAN: Mr. Schofield?

MR. SCHOFIELD: There is one small point I would like to discuss. These co-operatives are not affiliated directly with the medical profession. They are purely and completely consumer-sponsored. There is no connection between this statement and the following one.

We have experimented as is indicated in our brief here with going beyond the pure provision of medical coverage; we have moved into what is known as the major medical field. For a premium, usually of \$10 a year for a family, we offer to give a re-insured guaranteed contract of up to \$5,000 per annum for such





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THE CHAIRMAN: Mr. McLaughlin?

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are not affiliated directly with the medical profession.  
They are purely and completely consumer-sponsored.  
There is no connection between this statement and the  
following one.

We have experienced as is indicated in  
our report what goes beyond the mere provision of  
medical coverage; we have moved into what is known as  
the preventative field. For a premium, usually of \$10  
a year for a family, we offer to give a re-examined  
a reduced cost of up to \$100 per annum for each



Schofield

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things as dentists, nurses and ambulances. We have also in the works, and with complete agreement, plans and developmental situations with other professions of the healing arts whereby we will get group purchase of service.

The connection we have with the Group Health Association of America is a very pleasant one as far as we are concerned because we are much in favour of what has been done. Before anyone else on the Committee makes any comments about it I would like to get into the record we would strongly urge you to visit or contact, if you haven't already done so, the Group Health Association of Puget Sound, which is a pure co-operative, as is ours. It is doing a job we would like to do if we can get the co-operation of other parties here in Ontario.

THE CHAIRMAN: I might say it has been our intention to look at the Puget Sound, and also the Drug Co-operative which is operated just in the same general area. Now, you have member organizations in 29 counties. Can you give us the total membership in Ontario, total of the 29 member county organizations?

MR. SCHOFIELD: How many bodies; about 272,000.

THE CHAIRMAN: 29 counties - what is the distribution throughout the province, starting on the basis of about 65 counties in the province?

MR. SCHOFIELD: Some county co-operatives cover more than one county. We have a co-operative which is called Stor-Dun-Glen, which covers three counties as implied by the name.

THE CHAIRMAN: How many counties in total





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TORONTO, ONTARIO

Schofield 9106

will be covered by the 29 member groups?

MR. SCHOFIELD: All counties with the exception of perhaps three county groups which we don't go into. They are not members of our Federation and we reserve a hands-off policy in those counties, but all other counties are covered.





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Continued

will be covered by the 12 member group.  
R. SCHILLING: All countries with the  
exception of perhaps three county groups which we don't  
go into. They are not members of our federation and we  
reserve a hands-off policy in those countries, but all  
other countries are covered.



McCoig 9107

MR. McCOIG: I would like to add, Mr. Chairman, to that. One county in particular covers the area north known as Algoma up in Manitoulin Island, in that area.

THE CHAIRMAN: For lack of another designation, you continue to call them county organizations?

MR. McCOIG: Yes. It comes under the one heading, under the earned income but they do administer plans in that area.

THE CHAIRMAN: Do you go further north-west to the Lakehead? In that area?

MR. SCHOFIELD: No. We have not as yet. It has the possible potential that we can do so, and we hope to do so eventually, but implanting the idea behind a cooperative is a long slow process and we have enough work here in Southern Ontario at the moment.

THE CHAIRMAN: Now, you mentioned having accepted as members those in the higher age brackets. Have you any limitation on acceptance of members?

MR. McCOIG: I would say no.

THE CHAIRMAN: Just whoever they may be in any area?

MR. SCHOFIELD: As a matter of interest, part of my job is that of attending all the annual meetings that I possibly can around the Province. Quite recently I was in Halton County at its annual meeting and I had the pleasure at that meeting of shaking hands with a new member, a lady who is 72 years old. She had just been taken in as a new member. Her mother also had just been taken in by the Cooperative.



Topic 2007

Mr. McGee: I would like to see...

Chairman, to that. The county in particular covers the area known as Algonquin in Manitowish Island, in that area.

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a member, a lady who is 72 years old. She had just...

been taken in as a new member. Her mother also had just...

been taken in by the cooperative.



Forshaw 9108

MR. FORSHAW: I might say that, in speaking of our age ratios, it shows that medical co-operatives are carrying a disproportionate share of older persons. There is an aging problem particularly in rural Ontario and any percentage applied to the whole population of older people is exceeded, I would say, 100% of the co-operatives, so we have a lot of older people.

THE CHAIRMAN: You charge a yearly premium?

MR. McCOIG: Yes.

THE CHAIRMAN: Or monthly, whatever it may be of X dollars. Have you found that on that basis you have enough money to provide the service that you contract to deliver?

MR. McCOIG: Yes.

MR. SCHOFIELD: In all cases.

MR. McCOIG: I would like to point out, Mr. Chairman, it has just been brought to my attention in one county in particular the major medical plan saw fit to increase the premium for people over age 65. Now, that just applied to their major medical plans.

THE CHAIRMAN: Is that this \$10.00 item?

MR. McCOIG: Yes. They increased that to \$15.00 for a family.

THE CHAIRMAN: \$10.00 is above the others?

MR. McCOIG: Yes. I would like to go a little further in making you acquainted with the operation of the major medical plan.





Topic: \_\_\_\_\_

Mr. McCORMACK: I might say that, in

some cases of our patients, it shows that medical care is  
given and that the patients are not in a position to pay for it.  
There is an area in the State of New York where the population is  
and any percentage applied to the whole population of the  
State is 100,000, 100,000, 100,000 of the population  
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THE CHAIRMAN: You change a year or

Mr. McCORMACK: Yes.

THE CHAIRMAN: Or monthly, whatever it  
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item?

Mr. McCORMACK: Yes. They in essence that

to \$10.00 for a family.

THE CHAIRMAN: \$10.00 is about the

amount?

Mr. McCORMACK: Yes. I would like to be

a little more in detail you determined with the plan  
tion of the major medical plan.



McCoig 9109

The major medical plan with a premium that prevailed, one of \$5.00, single person; \$10.00 for a family universally, has a deductible clause in it and if a member just carries a \$10.00 -- pays a \$10.00 premium to one of our counties, it is subject to \$500.00 deductible. 80% of the balance is paid and guaranteed to a limit of \$5,000.00.

In the counties where a surgical plan, and in many cases now combined with in-hospital medical, where that is taken by the same subscriber that deductible drops to \$200.00.

Going further are these counties who have an extended medical or as we heard this morning, I take it a comprehensive plan. Then the deductible drops again to \$50.00. The premium remains at the same level, but the deductible changes with the amount of coverage that is prepaid by their paying a fixed premium.

THE CHAIRMAN: I take it then, there is not a uniform premium throughout the counties?

MR. McCOIG: Yes.

THE CHAIRMAN: Necessarily?

MR. McCOIG: Right.

THE CHAIRMAN: What will be the variation? What will the variation be between counties in the premium?

MR. SCHOFIELD: Very, very slight. The highest major medical premium runs to \$15.00 or standard to \$10.00.

THE CHAIRMAN: I am talking about the ordinary premium. The basic premium.



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The major medical plan with a premium that provided one of \$5.00, single person; \$10.00 for a family unit; and a deductible of \$50.00 in its plan. A person just enters a \$10.00 -- pays a \$10.00 premium to one of our counties, it is subject to \$500.00 deductible. 80% of the balance is paid and guaranteed to a limit of \$5,000.00.

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MR. SCHULTZ: Very, very slight. The highest major medical premium runs to \$15.00 or stands at \$10.00.

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TORONTO, ONTARIO

McCoig 9110

MR. McCOIG: The basic premium for service?

THE CHAIRMAN: Yes.

MR. McCOIG: I would say, subject to correction by my Provincial Secretary, that in the neighbourhood of \$40.00 for a surgical only contract which has now been increased by some \$10.00 or \$12.00 when they add in-hospital medical to it. Annual premium for a family.

THE CHAIRMAN: You are not insuring home and office service?

MR. McCOIG: Some of the counties. In my particular county, sir, as of the 1st of April, they started on the expanded medical plan. That adds home and office calls to the former benefits available to all persons on their next renewal who had carried a surgical contract, and this is available to new members up until the age of 65.

THE CHAIRMAN: Now, on this county basis, what is the basis of organization? Just those who will join, or have you some minimum limits or maximum limits, or what?

MR. McCOIG: Originally, going back some fourteen or fifteen years, to get acquainted with the medical cooperatives, many cooperatives were started as an autonomous group of people, who wanted to get, in those days, prepaid hospital protection, not only for themselves, but for other people in the community.

THE CHAIRMAN: And then you moved into the other field when the hospitalization was taken over?





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THE CHAIRMAN: And then you moved into

the other field when the organization was taken over?



McCoig 9111

MR. McCOIG: "Well, we moved before that.

THE CHAIRMAN: "Your major move came, I take it, then?

MR. McCOIG: "Yes.

MR. SCHOFIELD: "The autonomy remains. Each of the counties is quite autonomous and looks after its own people. Because of its close connection with the people that live there, the Board of Directors is elected from among that membership that live in that county. Also group secretaries or local township and school district representatives who speak for the cooperative and represent the population.

THE CHAIRMAN: "I follow that. I was interested in knowing, if you can tell me, what your basic organization is. I mean is it just two or three people getting together? Must there be a certain percentage of the population of the county or what?

MR. SCHOFIELD: "Originally, when it started, there was a requirement set down as a guide-line by the Department of Insurance that there had to be 200 to start it off, sir, in the county. We are now at the point where we have attained growth, and we can bring in individuals from all over the county without setting up territorially defined groups where we have to get 50 or 100 or anything like that within a group.

MR. FORSHAW: "Originally, I might say, they were groups that were known to each other. They were school section groups. Women's Institute groups. Farm Federation locals, school teachers, quilting bees, all



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Mr. McCall: Well, we would, before

that.

THE CHAIRMAN: Your major move was

I take it, then?

Mr. McCall: Yes.

MR. SCHOFIELD: The autonomy remains.

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interested in knowing, if you can tell me, what your basic organization is. I mean is it just two or three people getting together? Is there no a certain percentage of the population of the county or what?

MR. SCHOFIELD: Originally, when it

started, there was a requirement set down as a guideline by the department of Insurance that there had to be 100 to start it off, sir. At that time, we had not at the point where we have attained growth, and we are now individualized from all over the county without setting up any artificially defined groups where we have to get to 100 or anything like that within a group.

MR. SCHOFIELD: Originally, I might say

that we have a group that were known to each other. They were school secretaries, Women's Institute groups, and so on. In the early days, school teachers, county board,





Forshaw

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groups where people knew one another; were willing to appoint a secretary to act as a collector for the group, then if a new person joins, they were assigned to one or other group as their applications came in and drives were put on from time to time and the recruitment program put on. Secretaries were made known to the people at the meeting, and they would sign up through their particular group secretary. Were loosely knit groups.

THE CHAIRMAN: Overhead was at a minimum?

MR. FORSHAW: For instance, in my case, our group was the number one. Our staff group was the number one in our county, the medical cooperatives, and one of the staff acted as a secretary. That group started out with about a hundred before any other plan was available. Has now declined somewhat, but still is in operation, basis of operation being employment in the particular institution.

THE CHAIRMAN: Now, you have your county organizations which cover whatever territory they may cover. How does it go about obtaining, or does it go about obtaining medical services of a particular physician, or how does it operate?

MR. McCOIG: We do not interfere. We only have prepaid medical protection for our members. We do not interfere in any way with doctor-patient relationships and we have no contract with the medical profession, although the way we are licensed, sir, we do pay the doctors directly.

THE CHAIRMAN: You pay the doctors directly?





911  
Tolson

groups where people know one another; were willing to  
appoint a secretary to act as a collector for the group,  
that if a new person joins, they were assigned to one  
or other group as their applications came in andatives  
were put on from time to time and the recruitment program  
put on. Secretaries were made known to the people at the  
meeting, and they would sign up through their particular  
group secretary. were loosely knit groups.

THE CHAIRMAN: Overhead was at a

minutes

MR. TOLSON: For instance, in my case,  
our group was the number one. Our staff group was the  
number one in our country, the medical cooperative, and  
one of the staff acted as a secretary. That group started  
out with about a hundred before any other group was avail-  
able. has now declined somewhat, but still is in opera-  
tion. lots of variation being employed in the particular

THE CHAIRMAN: Now, you have your

country organizations which cover whatever territory they  
may cover. how does it go about obtaining, or does it  
go about obtaining medical services of a particular  
physician, or how does it operate?

MR. TOLSON: We do not intend to do

of unpaid medical protection for our members. We do  
not interfere in any way with doctor-patient relationships,  
and we have no contact with the medical profession,  
excepting the way we are licensed, sir, we do pay the  
costs directly.

THE CHAIRMAN: You pay the costs



McCoig 9113

MR. McCOIG: Yes.

THE CHAIRMAN: You pay whoever the patient chooses? The patient chooses these doctors?

MR. McCOIG: Certainly.

THE CHAIRMAN: And it is no concern of yours. You pay on the basis of general practitioner or specialist.

MR. McCOIG: General.

COMMISSIONER STRACHAN: You have an established schedule of fees?

MR. McCOIG: Yes, the Ontario Medical Association in most cases. At the present time, sir, they have accepted --- the member counties I speak of now -- have accepted the 1962 general tariff. I would like to point out at this time, to elaborate a little further, in our major medical contract the word "general" was left out on purpose, so our members -- which is our prime concern -- can have some relief from specialist fees.

THE CHAIRMAN: I take it from your presence here you think this system that you have works all right?

MR. McCOIG: We think so, yes. I think it is very evident by the satisfaction given to us by our members. We attended with Mr. Schofield the members meeting in Essex County last week and I have attended several as President of the organization and there is no complaint. That is, not of a great nature. That is where we get our direction, sir. We are close to the consumer. We are looking after their interest and when we see a need, when they express a view what they need, such as Kent County



1911

Mr. McGee: Yes.

THE CHAIRMAN: You pay wherever the

part of the cost? The patient chooses these services?

Mr. McGee: Certainly.

THE CHAIRMAN: And it is no concern of

you. You pay on the basis of general practitioners or

specialist.

COMMISSIONER STRACHAN: You have an

established schedule of fees?

Mr. McGee: Yes, the Ontario Medical

Association in most cases, at the present time, at least,

have accepted --- the manner in which I speak of now --

have accepted the 1921 general tariff. I would like to

point out at this time, to elaborate a little further, in

our major medical contract the word "general" was left out

on purpose, so our members -- which is our only concern --

can have some relief from specialist fees.

THE CHAIRMAN: I take it from your

presence here you think this system that you have worked

all right?

Mr. McGee: I think so, yes. I think

it is very evident by the satisfaction given to us by our

members. We attended with Mr. Campbell the members meet-

ing in Essex County last week and I have attended several

as President of the organization and there is no complaint

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direction, sir. We are close to the consumer. We are

looking after their interests and when we see a need, when

they express a view that they need, such as West County





McCoig: 9114

when we moved into the home and office calls it was at their direction we were able to do this, because we were aware of the peoples' need.

THE CHAIRMAN: Are the finances of each of the county organizations separate from the finances of the others?

MR. McCOIG: Yes.

THE CHAIRMAN: Is there a grouping or pooling of the resources throughout the twenty-nine?

MR. McCOIG: Just for our re-insurance purpose, sir, in the major medical plan. We operate out of Mr. Schofield's office underwriting pool which we contribute a percentage of our earned income for the major medical premium and they come in at a certain level after the county has reached that level in our payments, if payment is large enough.

THE CHAIRMAN: That is a matter then, of re-insurance?

MR. McCOIG: Re-insurance, yes. And we run our own in that respect.

THE CHAIRMAN: Are you re-insured in the re-insurance industry?

MR. McCOIG: Yes. We re-insure ourselves. All twenty-nine counties are re-insured.

THE CHAIRMAN: There is a pooling to that extent? There is a definite pooling?

MR. McCOIG: Yes.

MR. SCHOFIELD: Where it is necessary, in any way like that there is a pooling, but with the surgical plan it's maintained on its own feet; within the





when we moved into the new and better place it was the  
first time that we were able to do this, because we were  
aware of the people's needs.

THE CHAIRMAN: And the financial part

each of the county organizations separate from the  
finances of the others?

MR. MCCOIG: Yes.

THE CHAIRMAN: Is there a provision on

pooling of the resources throughout the twenty-nine?

MR. MCCOIG: Just for our re-insurance

purpose, yes, in the major medical plan. We operate out

of Mr. Schell's office underwriting pool which we

contribute a percentage of our earned income for the major

medical premium and they come in at a certain level after

the county has reached that level in our payments, if

THE CHAIRMAN: That is a matter then, of

MR. MCCOIG: Re-insurance, yes. And we

run our own in that respect.

THE CHAIRMAN: Are you re-insured?

MR. MCCOIG: Yes, we re-insure our-

selves. All twenty-nine counties are re-insured.

THE CHAIRMAN: There is a pooling to

that extent? There is a definite pooling?

MR. MCCOIG: Yes.

MR. SCHILLING: Where is it necessary,

in any way, that there is a pooling, but with the



Schofield 9115

county group there is no pooling, or in the surgical plan it isn't done.

MR. FORSHAW: I might illustrate along that same line, Mr. Hall. At the inception of the surgical plan requirements, the requirements were that a county have 200 and in order that they might get going two or three, sometimes more counties went together and offered one contract, until each member county became large enough to offer on its own.

THE CHAIRMAN: Now, I just want to make one reference to your submission on Page 3, Paragraph 6, Sub-paragraph 3 where you say that any plan must be mandatory to make it effective. Do you want to expand on that, because I would have assumed from now that you were built on a voluntary basis?

MR. McCOIG: We are speaking there, sir, of a universal Ontario Association, Federal plan and we point out that we think this is the way it should be done. Many of us, and I think you will agree with me, do not like the word mandatory. We perhaps could have found a more effective word.

THE CHAIRMAN: The other word they use is compulsory.

MR. McCOIG: I could take that one step further, with your permission, and refer back to the Ontario Hospital Services Commission where they were the sole carriers in the field. Well, it's not quite mandatory, but there is nothing else available. We can put it that way.

MR. SCHOFIELD: When we prepared this



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...there is no feeling, or in the physical sense

that some time, Mr. Hall. At the inception of the situation

plan to eliminate, the requirements were that a certain

have 200 and in order that they might get going, two or

three, sometimes more down it went together and offered

the contract, and I am the number twenty before being

enough to enter on his own.

THE CHAIRMAN: Now, I am going to

make one reference to your statement on page 3, paragraph

of paragraph 2 was a you say that any plan must be

mandatory, or make it difficult, or you want to express

on that, because I would have assumed from now that you

were built on a voluntary basis.

W. H. HOOVER: He was a feeling that,

kind of a universal. On the Association, Federal Bureau and

we know that that we think this is the way it is, and

now, many of us, and I think you will agree with me,

do not like the word mandatory. The persons could have

made a more effective word.

THE CHAIRMAN: The other word that you

are suggesting,

W. H. HOOVER: I could take that as

at a certain, with your permission, and refer back to

the original historical background of the situation when it was

the only way to get it done, well, but not only

anyway, but the fact is that the word mandatory is a

very strong word.

THE CHAIRMAN: I am a member of the



Schofield 9116

brief, this was one of the words that caused us most trouble, because it is quite foreign to the nature of a cooperative, to speak of anything of a compulsory nature.

COMMISSIONER McCUTCHEON: Why do you speak of it then?

MR. SCHOFIELD: This was an elected basis. We compel no one.

COMMISSIONER McCUTCHEON: Why do you speak of it?

MR. SCHOFIELD: Why? I am sorry, I didn't get the question. Because we do not feel that evolution is moving fast enough to bring these things about. We have done an excellent job within our counties. This was slow. We want to do more faster and I believe that it is sometimes necessary to give way to the collective or selective virtues that are inherent to make a subject compulsory or mandatory to everybody. It's sometimes advantageous and this is one of the times it is advantageous, we feel.

COMMISSIONER McCUTCHEON: You say we want to do more. We want to proceed faster. Who is "we"?

MR. SCHOFIELD: The consumer-sponsored groups that we represent, sir.

COMMISSIONER McCUTCHEON: In any of the places are you going to be in this mandatory plan?

MR. SCHOFIELD: Well, to anticipate what you are driving at --- perhaps I shouldn't -- there may be no place for us. We may be out of business but if people are getting complete health care through some function or other, that wouldn't matter too much. A cooperative does not exist for profit. Purely for service.







ANGUS, STONEHOUSE & CO. LTD.  
TORONTO, ONTARIO

McCoig

9117

COMMISSIONER McCUTCHEON: I am a little curious. You have this great area in Ontario. You have offered a type of coverage that has been suggested to us elsewhere farmers and small businessmen find it difficult to obtain. What is your concern about the people who do not choose to take advantage of what you are offering?

MR. McCOIG: Our plans, sir, are purely optional. The people who have the protection are our best advertisement, shall we say, for what consumer-sponsored plans can do for them and that is about the extent of our promotion.





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Schofield

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4 COMMISSIONER McCUTCHEON: I accept  
5 that. Then, why this concern? People in your county  
6 know what you are doing, you are covering 270-odd thousand  
7 people. As you say, the whole philosophy of a  
8 co-operative is that it is elective, then what is your  
9 concern? I am just puzzled, what is your concern about  
10 the fellow next door who decides he will not join your  
11 Co-operative?

12 MR. SCHOFIELD: You are making it  
13 extremely difficult with the use of the word "concern"  
14 because if we try to answer that question we sound  
15 as if we are in Sunday School.

16 THE CHAIRMAN: That is not a bad place  
17 to be.

18 MR. SCHOFIELD: You will have to  
19 accept that as the answer. We feel that we do have a  
20 responsibility to our fellow men.

21 COMMISSIONER McCUTCHEON: I see.

22 MR. FORSHAW: May I ask you this; it  
23 is my feeling that when we are completely elective that  
24 those who did not come in might so undermine the plan,  
25 even if the majority wanted it, it could not be effective.  
26 I think that we can cite one little hospital plan that  
27 had to change its plan of operation because of low  
28 participation.

29 THE CHAIRMAN: Has that been your  
30 experience?

MR. FORSHAW: We could do a better  
job sir, that would be a higher percentage of our people.  
This is one problem with the rural people, they tend to





COMMITTEE REPORT: I accept

Next, then, the this concern? People in your country  
know that you are doing, you are covering the old thousand  
people. As you say, the whole philosophy of a  
co-operative is that it is electric, then what is your  
concern? I am just puzzled, what is your concern about  
the fellow next door who decides he will not join your  
co-operative?

MR. SCHOTTE: You are making it

extremely difficult with the use of the word "concern."  
Because if we try to answer that question we cannot  
as we are in Sunday School.

THE CHAIRMAN: That is not a bad place

to be.

MR. SCHOTTE: You will have to

accept that as the answer. We feel that we do have a  
responsibility to our fellow man.

COMMITTEE REPORT: I see.

MR. SCHOTTE: May I ask you this; it

is my feeling that when we are completely electric that  
those who did not come in might as well be the pig.  
Over it, the majority wanted it, it could not be otherwise.  
I think that we can cite one little hospital plan that  
had to change its plan of operation because of low

THE CHAIRMAN: Has that been your

experience?

MR. SCHOTTE: It could be a better

plan, that would be a higher percentage of the people.  
This is the problem with the rural people, they tend to



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3 accept these things more slowly.

4 THE CHAIRMAN: Have you found the  
5 uninsurable flock to you or have you had a good number  
6 of the others other than people aging in the area?

7 MR. FORSHAW: The people coming to us  
8 are interested in doing things together and in fact  
9 our experience has been -- I think in that regard we  
10 have generally had the type of people we have had, with  
11 a few exceptions, people who have proved to be good  
12 experiences.

13 THE CHAIRMAN: I would think that  
14 one would say that this represents a very outstanding  
15 co-operative achievement in voluntary co-operation in  
16 the Province of Ontario and even in the Dominion of  
17 Canada.

18 MR. McCOIG: May I just add to that  
19 that our experience is official collectors of the  
20 Ontario Hospital Services Commission have made many  
21 rural people conscious of the need of prepaid hospital  
22 protection. We have helped too and hope to continue  
23 to do so. There are many problems in getting this  
24 organization started. Coming down here last night my  
25 notes have three persons, two of them who came to me  
26 yesterday morning from a lawyer's office asking if I  
27 would intercede with the Commission on their behalf  
28 because of the lapsed payments, not receiving their  
29 notices, et cetera. These are pay-direct people that  
30 I speak of.

MR. SCHOFIELD: I would make a comment  
on this abuse; we have a built-in deterrent because



...by these things now slowly.

THE CHAIRMAN: Have you found the

...is a flock to you or have you had a good number

of the other, other than people alone in the area?

MR. TOWNLEY: The people coming to us

are interested in doing things together and in not

our experience has been -- I think in that regard we

have generally had the type of people we have had, with

a few exceptions, people who have proved to be good

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protection. We have helped too and how to continue

to do so. There are many problems in relation to

operation around. Coming down here last night

notes have three persons, two of them who came to me

yesterday morning from a lawyer's office asking if I

would negotiate with the Commission on their behalf.

Because of the latest payments, not possible to

notice, at other. There are pay-amount notes that

I speak of.

MR. TOWNLEY: I would like to say

on this subject, we have a built-in element of need





Schofield

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4 you do not steal from your neighbours. Anybody who is  
5 contemplating medical care in the very near future it  
6 does not put the Co-op where the office might be next  
7 door or the group secretary next door at the head of  
8 the list he will attempt to join in order to provide  
9 for it.

10 COMMISSIONER McCUTCHEON: No, he  
11 will put the Government at the head of the list.

12 THE CHAIRMAN: Then, subparagraph you  
13 say you favour a -- is it implicit that you say you  
14 favour a premium plan?

15 MR. McCOIG: I would say that.

16 THE CHAIRMAN: Is that your position?

17 MR. SCHOFIELD: Perhaps even beyond  
18 that.

19 THE CHAIRMAN: I know you want a  
20 co-insurance but to begin with are you going to have  
21 the people pay for their protection or have it paid for  
22 out of taxes?

23 MR. McCOIG: I would feel if it would  
24 be paid for by premiums.

25 THE CHAIRMAN: And you favour also  
26 a developed system of co-insurance?

27 MR. McCOIG: Yes.

28 THE CHAIRMAN: As you have worked out  
29 with this other proposition covering your catastrophic  
30 coverage, the ten dollars and twelve dollars?

MR. McCOIG: We feel that is pointed  
out in number 6, that what we pointed out there is there  
is a definite need for it. We heard this morning  
marginal groups are unable to pay and we feel this is one





Ch. 1



McCoig

9121

way of doing it.

THE CHAIRMAN: Then those who are unable to pay for the full premium or part of it would expect to have help from the State through taxes in some form or do you accept that?

MR. McCOIG: Yes, but that, in just my personal opinion, would depend largely on what that premium would be, whether it is going to follow the line of the Ontario Hospital Services and pay subsidies where we are led to believe these subsidies were at both the Federal and Provincial level and the premium is within the reach of everyone at \$2.10 and \$4.20. That, in my opinion, is a very nice thing.

COMMISSIONER McCUTCHEON: If you are co-operative, I do not profess to be an expert but why are you concerned about your inability to compete effectively in the industrial field with physician-sponsored plans?

MR. SCHOFIELD: This comes under the reasoning of why we are inclined towards making the plan itself mandatory. The larger your base of approach the more effective your plan can be. We are, to some degree, prohibited because of this reduced rate that the physician-sponsored plans pay through getting into the younger employee market, the younger, relatively healthier employee market. We would like to have some of this cushion behind us so we could reduce the premium rate for everybody and extend benefits for everybody.

COMMISSIONER McCUTCHEON: Take a county where you have voluntary premiums and some benefits,



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way of doing it.

THE CHAIRMAN: Now, then, are

unable to pay for the full premium on part of it would

expect to have help from the State through taxes in

some form or do you accept that?

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plan itself mandatory. The larger your base of approach

the more effective your plan can be. We are, to some

degree, prohibited because of this insured rate that

the physician-sponsored plans pay through, putting into

the younger employee market, the younger, relatively

healthier employee market. We would like to have some

of this cushion behind us so we could reduce the premium

rate for everybody and extend it to the everybody.

THE CHAIRMAN: Now, then, are

county plans not have voluntarily accepted and some level



McCoig

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4 I judge from what you said that the Windsor Medical  
5 Services, how do the premiums compare?

6 MR. McCOIG: I am not fully acquainted  
7 although I live in the immediate area.

8 COMMISSIONER McCUTCHEON: What are  
9 your premiums?

10 MR. McCOIG: Our new premium which  
11 gives surgical, in hospital medical, home and office  
12 calls on the 1962 general tariff, a level premium  
13 annually, family \$99.60.

14 COMMISSIONER McCUTCHEON: Do you  
15 realize that is lower than the group premium in the  
16 Windsor Medical Services?

17 MR. SCHOFIELD: I would like to add  
18 that it also includes drugs, ambulance and nursing ---

19 MR. McCOIG: No, this is our extended  
20 medical, that is what the Commissioner asked for.

21 MR. SCHOFIELD: I am sorry, I am  
22 corrected.

23 MR. McCOIG: I would like to point out  
24 we have limits on this plan of \$200.00 per person  
25 annually.

26 COMMISSIONER McCUTCHEON: Co-insurance  
27 of \$200.00?

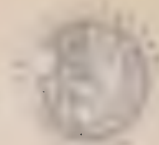
28 MR. McCOIG: No, a limit, a ceiling  
29 for home and office calls only.

30 COMMISSIONER McCUTCHEON: No limit  
on surgery?

MR. McCOIG: No.

COMMISSIONER McCUTCHEON: No limit on  
in hospital?





I agree that you have the right to feel

services, how do you think about it?

Mr. [Name]: I am not sure about it.

Although I live in the [Location],

the [Location] is not very good.

How do you feel?

Mr. [Name]: I am not sure about it.

Five students in hospital, some are

called on the [Location] to help, a [Location] to help.

I would like to know the [Location] to help.

Because that is how the [Location] to help.

What do you think about it?

Mr. [Name]: I would like to know

that it also includes [Location] and [Location].

Mr. [Name]: I think it is very good.

Because, that is how the [Location] to help.

Mr. [Name]: I am not sure about it.

concerned.

Mr. [Name]: I would like to know

how many [Location] on [Location] to help.

Mr. [Name]: I think it is very good.

Because, that is how the [Location] to help.

Mr. [Name]: I am not sure about it.

Although I live in the [Location],

the [Location] is not very good.

How do you feel?

Mr. [Name]: I am not sure about it.

Although I live in the [Location],

the [Location] is not very good.



McCoig

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MR. McCOIG: Yes, sixty calls per person per contract year just for the in hospital medical.

THE CHAIRMAN: The \$200.00 would appear to cover most of the home and office visits?

MR. McCOIG: Yes.

THE CHAIRMAN: That is much above the average?

MR. McCOIG: We charge \$10.00 above that for a major medical program which bears a \$50.00 deductible for the benefit of the outgoing patient.

COMMISSIONER McCUTCHEON: I speak from a valley of ignorance but I do not see why you cannot compete with employer groups in those circumstances, at least in Kent County.

MR. McCOIG: Shall we say we have just been in operation with this extended medical plan for five weeks and our advertising is just getting out. I am not going to look behind me to see who is here but we have had a great deal of interest displayed by the doctors in the last few days.

THE CHAIRMAN: I have no doubt.

COMMISSIONER McCUTCHEON: You believe in co-operative competition?

MR. McCOIG: If that is the way you want to put it, yes.

MR. SCHOFIELD: I would like to point out too that because of the nature of our structure we do not have vast resources that we can go ahead with a vast advertising campaign, we do not have vast armies of salesmen to put out on the road to publicize our





McCoig

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co-operative work. This is all done by word of mouth and that is slow.

MR. McCOIG: Satisfied customers are our best advertising.

MR. FORSHAW: In the case of our own particular co-operative we compete against a physician-sponsored plan without submitting a proposal to the largest co-operative group in the province, the employees of the largest co-operative group in the province. I feel we were only able to get them because we were co-operative because it seems to me manifestly impossible to pay one hundred cents on the dollar and compete against a second group who are able to obtain a 90% settlement basis. Now, I have been interested in this for some time because I know of another province in which the situation is different, the Province of British Columbia. I believe that the C.U. and C. government employees medical services plan settled with the medical profession on the same basis as these physician-sponsored plans. The situation which prevails in British Columbia does not prevail in Ontario in that we are required to pay one hundred cents in full settlement for the physicians' services.

COMMISSIONER FIRESTONE: Mr. McCoig, could you explain to us a little the relationship between the Co-operative Medical Services Federation and the co-operatives?

MR. McCOIG: Yes, I will endeavour to do that to your satisfaction. The Co-operative Medical Services Federation of Ontario is purely a





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co-operative work. This is all done by word of mouth  
and that is slow.  
MR. MCCORMACK: That is all right. I am not  
at all interested in that.  
MR. MCCORMACK: In the case of our own  
national co-operative we compete against a physician-  
sponsored plan without submitting a proposal to the  
lowest co-operative group in the province, the employees  
of the largest co-operative group in the province. I  
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against a second group who are able to obtain a 90%  
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the medical profession on the same basis as these  
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in British Columbia does not prevail in Ontario in  
that we are required to pay one hundred cents in full  
and interest for the medical services.

would you explain to us a little the relationship  
between the Co-operative Medical Services Federation  
and the co-operatives?  
MR. MCCORMACK: Yes, I will endeavour  
to do that to your satisfaction. The Co-operative  
Medical Services Federation of Ontario is mainly a



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TORONTO, ONTARIO

McCoig

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3 co-ordinating body financed, as previously outlined,  
4 by assessments, percentage-wise based at annual meeting  
5 and then assessed on the earned annual income of the  
6 member counties. We have no actual control or teeth  
7 in our relationship with the counties, we only recommend  
8 the principles and major changes in contracts which we  
9 think would be beneficial but it is purely optional  
10 whether some of these counties accept this.  
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co-ordinating body financed, as previously outlined,  
by assessments, percentage-wise based on annual meeting  
and then assessed on the earned annual income of the  
member countries. We have no actual control or touch  
in our relationship with the countries, we only recommend  
the principles and major changes in contracts which we  
think would be beneficial but it is purely optional  
action on some of these countries except this.

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COMMISSIONER FIRESTONE: You mentioned earlier you also performed certain re-insurance functions?

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MR. McCOIG: Yes.

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COMMISSIONER FIRESTONE: How do you perform those functions? Where do you get the funds for it, how does it work?

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MR. McCOIG: When we started in the major medical field -- and I believe we say this with some pride, that we were the first in Ontario to come out with a catastrophy plan; in other words, we led the field -- in consultation with the Department of Insurance here in Toronto it was pointed out we would have to have adequate reserves in order to give a guarantee contract, and after due consideration I was asked if I would be the first administrator and help to set up the plan, and we asked from the participating counties a contribution of \$2,000.00 as a minimu, with a maximum of \$5,000.00 that they would deposit to start the underwriting pool, with a ceiling of \$100,000.00. When they made these initial deposits we then made an assessment and reduced their inital deposit by the year from the assessments on their earned income and an annual assessment on a family of \$1.50, 15% of \$10.00 or twelve and a half cents per family per month, and these counties remit on the start, they did not remit cash because the deposit was already there, but it was reduced as their records came in.

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COMMISSIONER FIRESTONE: Are the member co-operatives satisfied and welcome this arrangement of a co-operative body, bring them together?





Q. Now, you also performed certain re-insurance functions earlier?

A. Yes.

Q. How do you

perform those functions? Where do you get the rates for it, how does it work?

A. Well, when we started in the re-insurance field -- and I believe we say this with some pride, that we were the first in Ontario to come out with a catastrophe plan; in other words, we led the field -- in consultation with the Department of Insurance here in Toronto it was pointed out we would have to have a separate reserves in order to give a guarantee contract, and after due consideration I was asked if I would be the first administrator and help to set up the plan, and we asked from the participating companies a contribution of \$2,000.00 as a minimum, with a maximum of \$5,000.00 that they would deposit to start the underwriting pool, with a ceiling of \$100,000.00.

When they made these initial deposits we then made an assessment and reduced their initial deposit by the year from the assessments on their earned income and an annual assessment on a family of \$1.00, less of \$10.00 on twelve and a half cents per family per month, and these companies remit on the start, they did not remit at first because the deposit was already there, but it was reduced as their records came in.

Q. Are the

now a co-operative association and welcome this arrangement of a co-operative body, bring them together?



McCoig

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MR. McCOIG: Yes.

COMMISSIONER FIRESTONE: They are happy with the arrangement?

MR. McCOIG: Yes, they are happy with the arrangement.

COMMISSIONER FIRESTONE: It has worked well?

MR. McCOIG: It has worked well. And I would go just a little bit further. There has been some discussion to try to set up a plan to re-insure the whole operation, but these are things which have to be worked out; you can't go into this because you get into these aspects of poor risk selection, poor operation, et cetera. But there has been discussion on that point at our annual meeting.

COMMISSIONER FIRESTONE: If you were here this morning, Mr. McCoig, you are familiar with the questions I have been asking of P.S.I. and the Windsor Medical Service as to the possibility of setting up a co-ordinating body embracing all voluntary, non-profit medical care plans in the Province of Ontario so that if the Government of the Province of Ontario were to decide on a medical care plan it could deal with an agency, one agency rather than close to 40 agencies to administer such a plan, draw on the experience already in existence.

Now, you have been telling us this afternoon that you have already done so on a small scale, you have built up a co-ordinating body and you have found that it has worked well. Could you visualize this



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MR. WATSON: Yes.

COMMISSIONER TIERNEY: They are

happy with the arrangement.

MR. WATSON: Yes, they are happy with

the arrangement.

COMMISSIONER TIERNEY: It is a matter

of

I would go just a little bit further. There has been

some discussion to try to set up a plan to re-engage

the whole operation, but there are things which have

to be worked out; you can't go into this because you

get into these aspects of poor sick selection, poor

operation, et cetera, but there has been discussion

on that point at our annual meeting.

COMMISSIONER TIERNEY: If you were

here this morning, Mr. Watson, you are familiar with

the questions I have been asking of P.C.I. and the

Ontario Medical Society as to the possibility of setting

up a coordinating body comprising all voluntary, non-

profit medical care plans in the Province of Ontario

as far as the Government is the Province of Ontario

were to decide to set up a medical care plan it could deal with

an agency, one agency rather than a number of agencies

to administer such a plan, based on the experience already

in existence.

Now, you have been talking of this

arrangement that you are ready to go on a small scale

and have built up a coordinating body and you have

found that it has worked well. Would you mind telling me





McCoig

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4 co-ordinating body you have created being expanded to  
5 cover all medical care plans, voluntary, non-profit,  
6 of the Province of Ontario, and if you could visualize  
7 such a plan would your own group be prepared to join  
8 such a broader co-ordinating body?

9 MR. McCOIG: I think, sir, our  
10 organization would be very receptive to discuss that  
11 and be prepared to offer suggestions to a co-ordinating  
12 body, and we point out that the co-ordinating body  
13 should have representatives from consumers across the  
14 province.

15 COMMISSIONER FIRESTONE: Thank you  
16 very much. Now, you speak on page 3 in paragraph 6,  
17 subparagraph 2, that you would recommend that each  
18 insurer be required to accept its share of substandard  
19 risks in the interest of universal coverage. Is this  
20 recommendation applicable to non-profit organizations or  
21 to both profit and non-profit organizations?

22 MR. FORSHAW: Well, one of the reasons  
23 that that is in, sir, is because certain of our medical  
24 co-operatives receive applications from persons who have  
25 been dropped at age 65 from an insurance contract because  
26 they have retired. They are, because of age, substandard  
27 and we would very much like to take them, but we could  
28 become overloaded with them. It is our feeling that  
29 in the interest of universal coverage we each should  
30 accept that in something the same manner as assigned  
risks are done in automobile insurance, and so on. There  
would have to be an assigned risk program so one group  
would not be overloaded, so there would be some place to





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co-ordinating body you have created being expanded to  
cover all medical care plans, voluntary, non-profit,  
of the Province of Ontario, and if you could visualize  
such a plan would your own group be prepared to join  
such a broader co-ordinating body?

MR. MCCOY: I think, sir, our

organization would be very receptive to discuss that  
and be prepared to offer suggestions to a co-ordinating  
body, and we point out that the co-ordinating body  
should have representatives from consumers across the  
province.

COMMISSIONER HIRSTON: Thank you

very much. Now, you speak on page 3 in paragraph 6,  
paragraph 2, that you would recommend that each  
insurer be required to accept its share of substantial  
risks in the interest of universal coverage. Is this  
recommendation applicable to non-profit organizations or  
to both profit and non-profit organizations?

MR. FORSHAW: Well, one of the reasons

that it is in, sir, is because certain of our medical  
co-operatives receive applications from persons who have  
been dropped at age 65 from an insurance contract because  
they have retired. They are, because of age, substantially  
and we would very much like to take them, but we could  
be overburdened with them. It is our feeling that  
in the interest of universal coverage we even should  
accept that in something the same manner as assured  
risks are done in automobile insurance, and so on. They  
would have to be an assumed risk proper to the group  
would not be a selected, so there would be some place



McCoig

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4 get coverage.

5 COMMISSIONER FIRESTONE: Would this  
6 relate to non-profit organizations as well as commercial  
7 carriers?

8 MR. FORSHAW: Yes, as well as  
9 commercial carriers.

10 COMMISSIONER FIRESTONE: To come to  
11 the following paragraph in which you submit your  
12 recommendation that such a plan should be mandatory,  
13 I think you are quite happy with the progress that  
14 you have made yourself but that you feel in the interest  
15 of providing a comprehensive medical care service for  
16 all the people of the Province of Ontario you would  
17 prefer to make this progress more rapidly, and the way  
18 you can see it being achieved is through a mandatory  
19 program?

20 MR. McCOIG: I think that is our  
21 thinking, sir.

22 THE CHAIRMAN: Those that don't want  
23 it have to take it anyway?

24 MR. McCOIG: Coming back to this ---

25 THE CHAIRMAN: Is that the implication?

26 MR. McCOIG: When the word "mandatory"  
27 is used I would say that is the implication. But going  
28 back to what I said previously, I believe that any plan  
29 of this sort to be effective should follow somewhat  
30 the pattern of the Ontario Hospital Services Commission,  
otherwise if you do not do that this proposed plan will  
get people who are in need of it at all times and you  
will not get the good risk.



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not otherwise.

relate to non-profit organizations as well as commercial

carriers?

MR. McLEOD: Yes, as well as

commercial carriers.

THE CHAIRMAN: To come to

the following paragraph in which you suggest your

recommendation that such a plan should be mandatory,

I think you are quite happy with the progress that

you have made yourself but that you feel in the interest

of providing a comprehensive medical care service for

all the people of the Province of Ontario you would

prefer to make this progress more rapidly, and the way

you can see it being achieved is through a mandatory

MR. McLEOD: I think that is our

thinking, sir.

THE CHAIRMAN: Those that don't want

it have to take it or leave it.

MR. McLEOD: Going back to this --

THE CHAIRMAN: Is that the implication

MR. McLEOD: When the word "mandatory"

is used I would say that is the implication, but going

back to what I said previously, I believe that any plan

of this sort to be effective should follow somewhat

the pattern of the Ontario Hospital Services Commission,

otherwise if you do not do that this proposed plan will

not people who are in need of it at all times and you

will not get the best results.





McCoig

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4 COMMISSIONER FIRESTONE: In other  
5 words, you would like to see the risk spread over all  
6 the people of Ontario?

7 MR. McCOIG: Yes.

8 COMMISSIONER FIRESTONE: May I deal  
9 with paragraph 5 where you recommend a system of co-  
10 insurance. I wonder if we could have some advice from  
11 you a little bit more specific as to what you mean by  
12 co-insurance. Do you have in mind that a patient will  
13 pay the first dollar of his visit to a doctor or do you  
14 have in mind he would have to pay for the first \$25.00?  
15 What would you have in mind as to co-insurance if a  
16 comprehensive and mandatory program were adopted?

17 MR. FORSHAW: In order to avoid any  
18 over-use, it was felt when our committee prepared this  
19 brief that a small co-insurance would tend to reduce  
20 the cost considerably and work no hardship on anyone.  
21 We had the experience for a number of years of \$10.00  
22 deductible on any hospitalization, and it was highly  
23 effective. When we discontinued it due to the fact that  
24 other plans offered no deductible, we had to raise our  
25 rates considerably. It is true that in most cases we  
26 paid a small percentage of the bill. So it was the  
27 feeling of the members of the committee that prepared  
28 this brief and passed it to the Board that the dollar-a-  
29 day, dollar-a-visit, subject to a maximum of, say,  
30 \$30.00, or \$10.00 for drugs, or some other similar  
co-insurance or deductible feature would facilitate the  
operation of the plan and reduce the cost, including  
those who didn't use it.





...in other

...you would like to see the risk spread over all

the people of Ontario?

...I am

...I am

...with regard to the system of co-

insurance, I wonder if we could have some advice from

you a little bit more specific as to what you mean by

co-insurance. Do you have in mind that a patient will

pay the first dollar of his visit to a doctor or do you

have in mind he would have to pay for the first \$25.00?

What would you have in mind as to co-insurance? Is it a

comprehensive and satisfactory program were adopted?

MR. TOLSON: In order to avoid any

overhead, it was felt when our committee planned this

that a small co-insurance would tend to reduce

the cost considerably and work no hardship on anyone.

As for the experience for a number of years of \$10.00

deductible on any hospitalization, and it was a very

effective. When we discontinued it due to the fact that

other plans offered no deductibles, we had to raise our

rates considerably. It is true that in some cases we

paid a small percentage of the bill. So it was the

feeling of the members of the committee that perhaps

this bill and passed it to the Board that the dollar-

day, dollar-a-visit, subject to a maximum of, say,

\$25.00, or \$10.00 for drugs, or some other similar

co-insurance on hospitalization would distribute the

operation of the plan and reduce the cost, and using

those who didn't use it.



McCoig

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4 COMMISSIONER FIRESTONE: In other  
5 words, the objective you have in mind in this co-insurance  
6 feature is to encourage a sense of responsibility among  
7 the insured?

8 MR. FORSHAW: Yes. I am referring  
9 to another medical co-operative who, for many years, have  
10 paid on the second and subsequent visits.

11 COMMISSIONER FIRESTONE: Of course,  
12 if you discourage the first visit you discourage one of  
13 the objectives you seem to have, and that is preventive  
14 medicine. Sometimes it is the first visit that could  
15 do the most good.

16 MR. FORSHAW: This is a reason why  
17 we didn't spell it out, that someone was more experienced  
18 could help on it.

19 COMMISSIONER FIRESTONE: In other  
20 words, a dollar deductible for the second and subsequent  
21 visits would be preferable to paying for the first visit,  
22 you feel?

23 MR. FORSHAW: Correct.

24 COMMISSIONER FIRESTONE: My last  
25 question relates to the comprehensiveness of your  
26 recommendation. That is, do you have in mind that we  
27 should have a comprehensive health care plan and what  
28 do you include in the term "comprehensive"?

29 MR. McCOIG: I feel that a comprehensive  
30 plan should give protection for all phases of medical  
31 care.

32 COMMISSIONER FIRESTONE: And that  
33 would include physical and mental health?



THE UNIVERSITY OF CHICAGO

...the initiative was in fact in this connection  
...is to encourage a sense of responsibility among  
...themselves

MR. F. L. ...

...to another ... who, for many years, have  
...paid on the second and subsequent visits  
...of course.

...the first visit you discourage one of  
...the ... you seem to have, and that is a ...  
...it is the first visit that would  
...be the best.

MR. F. L. ...

...we didn't spell it out, that someone was more experienced  
...could help on it.

MR. F. L. ...

...a dollar ... the second and subsequent  
...it would be ... for the first visit.  
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MR. F. L. ...

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...that is, as you have in mind that we  
...a ... plan and that  
...in the term "..."

MR. F. L. ...

...give ... of ...  
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MR. McCOIG: Yes.

COMMISSIONER FIRESTONE: It would include preventive medicine as well as curative?

MR. McCOIG: Yes.

COMMISSIONER FIRESTONE: It would include paramedical care services, drugs?

MR. McCOIG: Yes.

COMMISSIONER FIRESTONE: Would it include dental services?

MR. McCOIG: Yes. I think that is an important thing.

COMMISSIONER FIRESTONE: So it would include the whole array of medical health services of a personal nature?

MR. McCOIG: Yes.

COMMISSIONER FIRESTONE: Thank you very much. You have been most helpful.

COMMISSIONER BALTZAN: Just one question, gentlemen. You impressed me as being both a very progressive and successful organization. Do I understand you that you are essentially a lay organization, composed of lay people?

MR. McCOIG: Completely.

COMMISSIONER BALTZAN: My one question is this. Do you have any medical people or people with medical knowledge to assist you in certain matters such as the question at times regarding over-utilization, sometimes regarding over-servicing, and at time scrutinizing accounts?

MR. McCOIG: Speaking for my own





COMMISSIONER FLETCHER: It would

include preventive medicine as well as curative?

COMMISSIONER FLETCHER: It would

include paramedical care services, dental

MR. MCCOIG: Yes.

COMMISSIONER FLETCHER: Would it

include dental services?

MR. MCCOIG: Yes. I think that is an

important thing.

COMMISSIONER FLETCHER: Is it would

include the whole array of medical health services of

a personal nature?

MR. MCCOIG: Yes.

COMMISSIONER FLETCHER: Thank you very

much. You have been most helpful.

COMMISSIONER FLETCHER: Just one

question, gentlemen. You impressed me as being both a

very progressive and successful organization. Do

you understand you that you are essentially a lay organization?

Answered by people?

MR. MCCOIG: Completely.

COMMISSIONER FLETCHER: My one question

is this. Do you have any medical people on parole with

medical knowledge to assist you in certain matters such

as the question of times regarding over-exercising,

sometimes running over-exercising, and at times

MR. MCCOIG: Speaking for my own



McCoig

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4 Co-operative, Kent Co-operative Medical Services, we  
5 discuss with our medical advisor certain claims, I  
6 being a layman am not entirely familiar with all the  
7 terms of the medical profession, and if a claim seems  
8 to be a little higher than the O.M.A. standard, then  
9 I look twice.

10 COMMISSIONER BALTZAN: You have given  
11 me the complete answer. Thank you.

12 THE CHAIRMAN: Thank you very much,  
13 Mr. McCoig and gentlemen. It has been a very profitable  
14 experience to discuss this matter with you gentlemen.

15 We now proceed to the next one,  
16 Trans Canada Medical Plan.  
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document as, Kent Co-operative Medical Service, we

it with our medical and son certain clause, I

but a lawyer or not entirely familiar with all the

terms of the medical profession, and if a claim seems

to be a little higher than the U.M.A. standard, then

I am afraid.

COMMISSIONER PATTERSON: You have given

the complete answer. Thank you.

THE CHAIRMAN: Thank you very much.

Mr. McGoey and gentlemen. It has been a very profitable

experience to discuss this matter with you gentlemen.

We now proceed to the next one.

Trans Canada Medical Plan.

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THE SECRETARY: Mr. Chairman, Dr. MacCharles will address the Commission and will present his group. His brief will be known as Exhibit 245.

--- EXHIBIT NO. 245: Submission of Trans-Canada Medical Plans (1960).

SUBMISSION OF TRANS-CANADA MEDICAL PLANS (1960)

Appearances: Dr. M.R. MacCharles  
Prof. T. Matuszewski  
Mr. C.H. Shillington  
Dr. J.A. MacDougall  
Dr. J.O. Lockhart

THE CHAIRMAN: Dr. MacCharles?

DR. MacCHARLES: Thank you. Mr. Chairman, Commissioners, I am Dr. MacCharles from Winnipeg, Chairman of the Commission. On my extreme left is Dr. Lockhart from Hamilton, who is Honorary Secretary of the Commission and one of the members of the Committee that has prepared the brief. Next to him is Dr. MacDougall from St. John, New Brunswick, who is Vice-Chairman of the Commission and also helped in the preparation of the brief.

On my right is Mr. Shillington, the Executive Director of Trans-Medical Plans and on his right is Professor Matuszewski of the University of Montreal, an economist who has helped us in the preparation of this brief.

We had another consultant, a medical economist, who helped us in preparing this brief who is unfortunately unable to be present. He is Dr. Nathan Sinai. We regard him as the most informed medical economist on the continent. He has had unlimited





MacGarras will address the Commission and will present his group. His brief will be known as Exhibit 145.

--- Exhibit 145, 146: Submission of Trans-Canada Medical Plans (1952).

STANDARD 1 OF THE ALASKA MEDICAL PLANS (1952)

Appointees: Dr. W.R. MacGarras  
Prof. J. J. MacGarras

THE CHAIRMAN: Mr. MacGarras?

DR. MACGARRAS: Thank you, Mr. Chair-

men, Commissioners, I am Dr. MacGarras from Winnipeg,

Chairman of the Commission. On my extreme left is Dr.

Lockhart from Hamilton, who is honorary secretary of

the Commission and one of the members of the Committee

that has prepared the brief. Next to him is Dr.

MacGarras from St. John, New Brunswick, who is vice-

chairman of the Commission and also helped in the prepara-

tion of the brief.

On my right is Mr. Smith, the

Executive Director of Trans-Canada Medical Plans and on his

right is Professor MacGarras of the University of

Montreal, an economist who has helped us in the prepara-

tion of the brief.

We had another consultant, a medical

economist, who helped us in preparing this brief who is

unable to be present. He is Mr. MacGarras.

I regard him as the most informed medical

economist on the continent. He has had extensive



MacCharles

experience. He was an active member of the American Medical Committee on Cost of Medical Care which started in 1929. Their deliberations then went on for five years. Following that he was Director of the Public Health Department, University of Michigan, in Ann Arbor until a year or two ago when he retired.

Like many retired people he is busier since his retirement than he was during his active years and has many commitments, not the least being he is consultant to Dr. Candeau, the Director-General of the World Health Organization. We are disappointed that he is not here to support us in the presentation of this brief, but we are more concerned that the Commission don't have the opportunity of hearing him and questioning him and drawing from his vast fund of knowledge.

I would like to have your approval, sir, to ask him to come here some time in the next few weeks while the Commission is still here and meet with you on some basis so that you can have that advantage of hearing his opinion on these matters.

THE CHAIRMAN: You could try and work that out, Dr. MacCharles, in conjunction with the Secretary, who would be familiar with the agenda and the time that we might be able to allot to him. Perhaps we may get some vacant space. We have a pretty tight schedule, as you know.

I would think it is quite feasible and leave it to yourself to work it out with Mr. Lafrance.

DR. MacCHARLES: Thank you very much, sir. I now propose to read the summary and conclusions



experience, he was an early member of the American  
National Association on Post-Operative Care (which stands)  
in fact, with the American Association on Post-Operative Care  
years, following that he was Director of the Public  
Health Service, University of Michigan, in Ann Arbor  
until a year or two ago when he retired.

Like many retired people he is busier  
since his retirement than he was during his active years  
and has many commitments, not the least being he is  
consultant to Dr. Fendley, the Director-General of the  
World Health Organization. We are disappointed that he  
is not here to support us in the presentation of this  
brief, but we are concerned that the Commission  
don't have the opportunity of hearing him and questioning  
him and getting from him vast fund of knowledge.

I would like to have your approval, sir,  
to let him to come here some time in the next few weeks  
while the Commission is still here and meet with you on  
some issue so that you can have that advantage of hearing  
his opinion on these matters.

Dr. Fendley: You could try and work  
that out, Dr. Fendley, in conjunction with the  
Secretary, who would be familiar with the agents and  
the time that we might be able to allot to him. Perhaps  
we may have some vacant space. We have a pretty tight  
schedule, as you know.

I would think it is quite possible, and  
leave it to yourself to work it out with Dr. Fendley.  
Dr. Fendley: Thank you very much.  
and I will propose to read the summary and conclusions





MacCharles

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here.

THE CHAIRMAN: Will you sit down.

DR. MacCHARLES: SUMMARY. 1. Accessi-  
bility and availability are the two major problems in  
the extension of health services to the people of Canada.  
In the context of its definition of accessibility, the  
T.C.M.P. submission deals with access to physicians'  
services through prepayment. The other, equally important  
matter of availability of health personnel, facilities,  
etc., is not discussed.

2. As the national organization which  
co-ordinates the efforts of those prepaid medical care  
plans throughout Canada sponsored or approved by the  
medical profession, T.C.M.P., drawing upon its decade of  
experience, has considered it important to speak of the  
complexities of the undertaking involved, to provide a  
panoramic analysis of the efforts of its own member plans,  
and to speak of the contribution of the physician in Canada  
to such developments.

3. Under "Principles and Criteria for  
Prepayment Plans" it is suggested that any plan to make  
physicians' services available to the people must be (a)  
medically sound, (b) socially sound, (c) economically  
sound and (d) administratively sound. In each case we  
have enumerated the desirable factors which contribute  
to such standards.

4. In analyzing our own member plans we  
have offered for consideration certain proposals which may  
overcome the final difficulties in the attainment of the  
objectives for which prepayment was designated.







MacCharles

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5. In particular, we wish to draw the attention of the Commission to certain key principles outlined in paragraph 76 which have been identified from the beginning with the structure and operation of all our sponsored plans. Arising from early research in Windsor, these key principles were offered as fundamental to the satisfactory provision of prepaid health services. Over the years since, they have continued to symbolize the end product of an arrangement in which the public and the medical profession have been joined.

6. What has been the effect of the application of these principles?

(1) More than 4.1/2 million Canadians now have coverage for the great percentage of their medical needs. Most of this is first dollar coverage and includes services of the physician in the home and office as well as in the hospital - the "easy access to physician" type of coverage conducive to the preventive aspects of medicine as well as to treatment and favoured both by the public and the providers of services.

(2) Service benefits provide full protection for many needed physicians' services.

(3) As to professional support, the answer is found first in the record of percentage of participating physicians and, secondly, in the C.M.A. survey of



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1. In addition, we wish to draw the

attention of the Commission to certain key principles outlined in paragraph 10 which have been identified from the various studies with the objective and intention of all our research being based on the same principles. These key principles were: (1) as fundamental to the statutory provision of our health services, (2) the need since they have continued to emphasize the importance of an approach in which the public and the medical profession have been joined.

2. What has been the effect of the

operation of these principles?

(a) More than 4.5 million Canadians now have coverage for the first time of their medical needs. Just a few years ago this was first class coverage and included services of the physician in the home and office as well as in the hospital - the "easy access to physician" type of coverage compared to the previous type of coverage of services as well as to treatment and covered both by the public and the providers of services.

3. Services provided by the

provision for many needed physicians' services.

(b) As to professional aspects, the

work is being done in the second in a series of participating areas and, secondly, in the C.A.A. survey of



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1960 in which 85% of the physicians of Canada in practice favoured such type of plan or method of prepayment above all others.

(4) The financial operations of such plans have personified efficiency and low cost operation.

(5) In the extension of coverage the plans have pioneered many new methods and arrangements, reaching out further and further to cover new groups of citizens.

(6) Such plans have not attempted to take over the control of quality of medical care but they have provided a vehicle by which the profession itself has a greater opportunity to exercise such function as part of its responsibility to the people of Canada.

7. In conclusion, this record of the established plans portrays nothing more nor less than the carrying out of the purpose for which they were intended - namely, to serve as agencies through which the services of the physicians of Canada could be made accessible through a prepaid mechanism to a substantial percentage of Canadian citizens.

8. To extend this accessibility to all persons in Canada is now the problem. For our own T.C.M.P. plans, as well as for other voluntary carriers, it must be admitted that there is a hard core group for





1960 in which 10 of the 15 firms  
(66%) in the industry favored such type  
of plan or method of procedure above  
all others.

(4) The financial operations of each  
firm have been characterized as follows:  
low cost operation.

(5) In the extension of coverage the  
plans have progressed from a method  
and arrangement, reaching out further  
and further to cover new groups of clients.

(6) Such plans have not attempted to  
take over the control of quality of  
medical care but have provided a  
vehicle by which the profession should  
and a greater opportunity to participate  
and function as part of the responsibility  
to the people of the state.

7. In conclusion, this report of the  
established by the Port Authority of New York and New Jersey  
concerning one of the purposes for which the Port Authority  
has been established and the services  
it has provided to the public of New York and New Jersey  
and the Port Authority of New York and New Jersey  
concerning the same.

8. It is the responsibility of the  
Port Authority of New York and New Jersey  
to provide the public with the best possible  
service and to maintain the same.



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whom the task of providing coverage is difficult and the results somewhat unspectacular. Included here are the aged, the unemployed or part-time workers and others in the low-income groups. For these persons to have such benefits some financial assistance from outside sources is necessary. If the principle be accepted that assistance should confine itself to this section of the population, then the problem becomes one of method only.

9. In Chapter IV of our submission, paragraphs 123 to 148, inclusive, we have proposed certain methods for assisting those in need, as well as suggesting certain other arrangements which, in our opinion, would achieve the goal of total accessibility to health coverage.

10. In brief, these are as follows:

(1) Service benefits to those requiring financial assistance

For that section of the population requiring financial assistance service benefits should be applied, in co-operation with the physicians as providers of service.

(2) Coverage through existing voluntary carriers

Coverage to such persons should be provided through the facilities of the existing voluntary agencies.

(3) Assisting needy groups on an identifiable basis

As certain of the groups needing help





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are easily identifiable and there is some advantage in utilizing existing agencies, one method by which such end might be accomplished would be to deal with the following as separate groups:

1. The 65 and over age group
2. The unemployed
3. The indigent
4. The medically indigent

In our Chapter IV, paragraphs 129 to 141, we have outlined more particularly our method of approach for each of these enumerated groups and the resulting cost of outside assistance which might be anticipated.

(4) Cover those with chronic illnesses in working population

For persons in the working population suffering from chronic illnesses, we suggest that all voluntary carriers who now exclude these people should make coverage available to them.

(5) Government support for educational programs on prepayment

Government support of programs of public education on the value of prepayment would offer a worthy service by encouraging members of the public to protect themselves. We suggest that this be considered.





and socially identified, and there is  
 some advantage in retaining existing  
 resources, one method in which and  
 might be adopted would be to deal  
 with the following as separate groups:

1. The 10 and over age group
2. The unemployed

4. The medically indigent  
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 we have outlined more particularly our  
 method of approach for each of these  
 enumerated groups and the resulting  
 cost of outside assistance which might  
 be anticipated.

(4) Cover those with chronic illnesses  
in the following manner:

For persons in the working population  
 suffering from chronic illnesses, we  
 suggest that all voluntary agencies who  
 now exclude these people should make  
 complete available to them.

(5) Cover the aged and infirm  
in the following manner:

Government support of programs of  
 public education on the value of prepay-  
 ment would offer a worthy service by  
 encouraging members of the public to  
 protect themselves, as we trust that  
 they are concerned.



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(6) Where financial assistance is involved, basic levels of benefits should be established

Wherever outside financial assistance is involved, basic levels of benefits should be established to which all persons receiving assistance would be entitled before such funds could be used.

(7) Standards of accreditation

Certain basic standards of accreditation should be applicable in all provinces to which all carriers licensed to do business in such province would be required to adhere.

(8) Continuation of coverage

Finally, to further ensure continuation of coverage for persons moving from province to province, all prepayment plans in whatever province they operate should be required to subscribe to an inter-plan transfer arrangement as is now in effect among T.C.M.P. plans.

With your permission, sir, in paragraph 11 I would like to change the wording just a little bit. We would like it to read this way.

11. With more than half the population of Canada now enjoying some measure of protection, with coverage being extended through financial assistance and otherwise to all the remaining sections of the population, with adequate standards of accreditation applicable





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to all carriers and with assurance of continuation of protection, the great percentage of those remaining sections of the population, with encouragement, may be expected in a reasonably short period of time to avail themselves of the opportunity available.

THE CHAIRMAN: Thank you, Dr. MacCharles. As we have done with the last two, do you wish to add some observations in light of what has been said in the discussion that has taken place up to now? I think we can appreciate you are in a different category from the three previous, a somewhat different category from the three previous groups today.

DR. MacCHARLES: We have listened, sir, with very great interest to these other discussions and we have made notes on them. I think a lot of the observations will come up in the questions we are going to be asked. If there are any left over we might ask for permission to make them later.

THE CHAIRMAN: Your Association is confined to those plans that are sponsored and approved by the medical profession?

DR. MacCHARLES: That is correct, sir.

THE CHAIRMAN: Is there any difference between sponsored or approved or are those two words - do they mean the same thing?

DR. MacCHARLES: Pretty nearly; I think they are more or less interchangeable.

THE CHAIRMAN: Are there any plans which are approved that are not sponsored?

DR. MacCHARLES: Yes, there is one in





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to all countries and with assistance of contribution of  
United States, the great percentage of those countries  
sections of the population, with encouragement, may be  
expected in a reasonably short period of time to have  
the services of the government available.

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some of the material in light of what has been said in the  
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Quebec which is an indemnity type of plan which is not sponsored by the medical profession, but approved.

THE CHAIRMAN: That answers that part of it. I notice in paragraph 2 of your main submission, on page 1, the member plans of such organization are - and you list them.

DR. MacCHARLES: That is right.

THE CHAIRMAN: One in Quebec; I take it it is the Quebec Hospital Service Association?

DR. MacCHARLES: That is right, sir.

THE CHAIRMAN: You don't cover Les services de santé or the group that just preceded you here this afternoon?

DR. MacCHARLES: No, sir.

THE CHAIRMAN: The Medical Co-op.

DR. MacCHARLES: No sir, they don't belong to T.C.M.P.

THE CHAIRMAN: They don't belong or is it possible that they could belong, or are they not eligible to belong?

DR. MacCHARLES: I think that would be a question that would have to be submitted to the O.M.A., the Ontario Medical Association. We would require their approval before we could take them in.

THE CHAIRMAN: Whether or not they are doctor-sponsored since you say you may have approved plans that are not doctor-sponsored.

DR. MacCHARLES: Actually the doctors expect their cheques, and in that respect they are approved by the individual doctors. I doubt that they



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2 have had official approval. I don't know.

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4 THE CHAIRMAN: The matter has not  
arisen?

5 DR. MacCHARLES: I don't know why.

6 DR. MacDOUGALL: Mr. Chairman, if that  
7 particular plant wishes to become a member of the Trans  
8 Canada Medical Plan and applied for approval to the  
9 Ontario Medical and were approved, there is no reason  
10 why they could not be accepted into our organization.

11 THE CHAIRMAN: There is nothing in  
your constitution that would exclude them?

12 DR. MacDOUGALL: No.

13 THE CHAIRMAN: That is perhaps a better  
14 way of putting it. Dr. Van Wart?

15 COMMISSIONER VAN WART: Mr. Chairman,  
16 may I ask the group do you see the voluntary doctor-  
17 sponsored medical care plan being able to come up with a  
18 program that would cover everyone?

19 DR. MacCHARLES: Yes. The answer to  
20 that is yes because this is what we started out to do  
21 originally. Our object was every man, woman and child  
in the nation, if possible.

22 COMMISSIONER VAN WART: What is the  
23 prospect for those of us in the 65-year and over area?

24 THE CHAIRMAN: I've got a companion now.

25 COMMISSIONER VAN WART: As individual  
26 subscribers?

27 DR. MacCHARLES: I sympathize with you  
28 sir. We think that this is one group that would be  
29 included and that needs careful study and actually since  
30 this brief has been written, the Canadian Medical





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MacCharles

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4 Association have had a little bit of new thinking on  
5 it which I am sure they will give you next week.  
6 Basically it is because many of them are financially  
7 embarrassed and have difficulty in paying the premiums  
8 and one other factor that is important and that is  
9 because looking after people over 65 it is considerably  
10 higher, by most people's opinion, than in the lower  
11 age groups. It has been estimated about as high as  
75% more.

12 There are some points in considering  
13 this group where things are looking a little brighter.  
14 More of the 65 to 70 group have had service plans for  
15 a long time and they are carried on after they retire  
16 from work. That is one help. The other thing is that  
17 pension plans have become a lot more frequent in the  
18 last -- since the war, I suppose, and their incomes  
19 will, therefore, be augmented a little. That will reduce  
20 it a little further. In addition to that, when any  
21 individual arrives at the age of 70, they get a pension  
22 then and that helps it a little bit further.

23 Countering that, of course, is the  
24 other point that the average age of the Nation is  
25 rising very rapidly and the numbers of people in the  
26 older age group is increasing very considerably so that  
the numbers are going to be quite high and so we have  
the whole combination of factors.

27 DR. MacDOUGALL: May I add that we  
28 think that the prospect within the plan itself is rather  
29 hopeful of carrying considerably higher percentage of  
30 this group. I think in fairness to all, it is questionable







MacDougall

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whether we can ever attain, without some outside assistance, the complete coverage of this group.

COMMISSIONER VAN WART: Have you been able to calculate how much the premium would have to be in order to cover those over 65?

DR. MacCHARLES: I think maybe Professor Matuszewski could help you on that.

PROF. MATUSZEWSKI: Yes, we have made a rough calculation. We have made certain calculations on these points. They are subject to a number of simplifying assumptions. Take me a few minutes to find it in my memo. Subject to various simplifying assumptions, which I cannot go into now, it will raise the premium by approximately, in our calculation, \$10.00 or just over \$10.00 per annum per member of the labour force.

COMMISSIONER VAN WART: \$10.00 per annum?

PROF. MATUSZEWSKI: Yes. That is if the total burden of contra-ing medical service to population, both under and over 65, was to be borne by members of the labour force the cost per member force would go up by about \$10.00, or just over \$10.00 per annum.

COMMISSIONER VAN WART: What are the reasons for the heavy percentage of cancellations by the people who pay direct?

MR. SHELLINGTON: Actually sir I think this is a misnomer, the suggestion that the cancellations are heavy. In the first place, statistics often can be misleading as well as helpful and this is the situation





(The Journal)

...then we can ever at last, without some outside assistance, the complete recovery of this group.

...HARRY: Have you been

...to calculate how much the premium would have to be in order to cover these over 85?

...HARRY: I think only

...the doctor would also say on that.

...HARRY: Yes, we have

...made a rough calculation. We have made certain calculations on these figures. They are subject to a number of

...slightly different figures. Take me a few minutes to find

it in my mind. Subject to various slight variations, it is in my mind, I cannot go into now, it will make the point

by approximately, in our calculation, \$10.00 or just

over \$10.00 per annum per member of the group for a

...HARRY: \$10.00 per

...HARRY: Yes, that is it

the total group of members the medical section is

population, 100,000 and over 85, was to be borne

by members of the group to see the most serious form

would be up by about \$10.00; or just over \$10.00 per

...HARRY: What is the

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...HARRY: Actually, I think

this is a situation, the situation is that we are

the heavy. In the first place, we are not

...as well as being and this is the situation



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3 where a particular system of recording -- for instance,  
4 you will find in looking at the statistical picture a  
5 series of heavy cancellations but in actual practice  
6 what it amounts to is a normal operation of people  
7 entering into jobs, discontinuing their individual  
8 coverage taking on the group coverage, or changing --  
9 they may depart the Province. Go somewhere. All these  
10 things end up showing as a cancellation.

11 A man can change business and switch  
12 from one occupation to another and the pictures of  
13 cancellation, as we have received them in our offices  
14 across the country, do have to be leavened with the  
15 facts of life that it isn't just a case of cancelling  
16 coverage and not taking something to replace it. It's  
17 a movement back and forth between group and individual  
18 and areas such as in the Province of Saskatchewan where  
19 they have individual coverage and have bought it; I  
20 think perhaps if the Plan didn't advise you of the long  
21 term picture that area after area has shown that the  
22 ratio of cancellations has been low. It has shown that  
23 because of the particular operating methods which are  
24 followed; tend to create a misleading picture but in  
25 the overall situation if you can count the number of  
26 people who took out coverage five years ago, or ten  
27 years ago, many of them still have it. It gives an  
28 entirely different impression. That is why I say that  
29 the suggestion of heavy cancellations on individual  
30 contracts does not always mean exactly what it shows.

31 COMMISSIONER BALTZAN: The subscriber  
32 cancels out or the insuring agent cancels them out? Two



where a political system of government is in operation, you will find in looking at the statistical picture a series of heavy cancellations in the actual picture. What it amounts to is a normal operation of people entering into jobs, discontinuing their individual coverage taking on the group coverage, or changing -- they may depart the Province, for example. All these things are not showing as a cancellation.

A man can change business and activity from one occupation to another and the picture of cancellation, as we have received that in our office across the country, do have to be lessened with the fact of it is that it isn't a case of cancelling coverage and not taking anything to replace it. It is a movement back and forth between group and individual and areas such as in the Province of Saskatchewan where they have individual coverage and have bought it; I think perhaps if the plan could advise you of the fact that picture that area it is shown that the same of cancellations has been shown. It has shown that because of the government's changing method which are followed; tend to create a cancelling picture but on the overall situation if you can count the number of people who took out a variety of years ago, on the years ago, many of them still have it. It is not an entirely different impression. That is why I say that the situation of heavy cancellations on individual coverage does not always mean exactly what it shows. Some of the cancellations are not shown.





Shellington

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types of cancellations. How do they compare?

MR. SHELLINGTON: I recognize sir that in the agreements of most plans there is a clause which provides a right of cancellation or termination. I think perhaps in actual practice, however, that there is only a one way road on this and that is the subscriber's decision to cancel.

COMMISSIONER BALTZAN: The subscriber?

MR. SHELLINGTON: Yes. The whole effort of these plans have been that once you buy any coverage, that you can keep it until death, if you are prepared to pay the premium.

COMMISSIONER VAN WART: Subsidizing by the Government of those who cannot afford to pay premiums themselves. Do you see that as a practical thing in the operation of the doctor-sponsored medical program?

DR. MacCHARLES: Certainly. We are doing that now, sir, in many areas. It provides no particular problem if you have negotiated with the Government to pay the premiums; the group of people go in another group and carry them on as an ordinary group in the plan.

THE CHAIRMAN: That is what you are doing in Medicare in Manitoba?

DR. MacCHARLES: Yes.

COMMISSIONER VAN WART: Has that been done in any of the other provinces?

MR. SHELLINGTON: There have been in other provinces limited efforts along this line. There was some in Saskatchewan. Some in Nova Scotia, British





types of cancellations. How is they connected  
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Q. Subsequent to that, the whole  
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Q. Now, I think you said that the  
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 program?

A. MacGillivray: Certainly, we are  
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 no in another group and carry over on an automatic  
 basis in the year.

Q. Now, I think you said that a whole lot of  
 doing in medicine in America?

Q. Now, I think you said that the  
 there is any of the other provinces?  
 A. I think there is a lot of  
 other provinces limited efforts along the line, the  
 was some in that town. One in Nova Scotia, British



Shellington

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Columbia, Ontario.

DR. MacCHARLES: They are being done in all the Provinces. Not all in that way and the arrangements they have in Manitoba at the moment is not too satisfactory because it only takes in home and office calls. The in-hospital care is being granted free, given free by the profession as a concession to the people interested in medical teaching. If all these people are private patients, that the medical school would lack patients for teaching the students and under-graduates and graduates.

THE CHAIRMAN: That is a fear that has not been fully analyzed.

DR. MacCHARLES: I think it is a fear that is greatly overrated. From the standpoint of serving these patients, it left a lot to be desired.

COMMISSIONER VAN WART: Ontario is not in hospital is it? They do not insure them in the hospital in the Medicare Welfare plan?

DR. LOCKHART: That is correct.

DR. MacCHARLES: It's an out of hospital coverage.

COMMISSIONER VAN WART: Does the method of operation of the medically-sponsored plan have any effect on the quality of care given?

DR. MacCHARLES: Yes, I think they have quite a helpful effect on the quality of medical care. Previous to the medically-sponsored plan a lot of the medical practice was known only to the patient and his physician. As soon as prepaid medicine came into



Columbia, Ontario.

MR. JAMES M. KELLY: That was a very good

in all the provinces, but all in that way and the

arrangements they have in Ontario at the moment is

not too satisfactory, but as it only takes in home and

office calls. The hospital care is being granted

free, given free by the profession as a concession to

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people are private patients, that the medical school

would look patients for teaching the students and

the government is not

THE CHAIRMAN: That is a very fine

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MR. JAMES M. KELLY: I think it is a

fact that is the only one, I am sure, of

giving these patients, it is a lot to be desired.

MR. JAMES M. KELLY: Ontario is

not in hospital is it? They do not insure them in the

system in the Medicare system?

MR. JAMES M. KELLY: Yes, they do.

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MR. JAMES M. KELLY:

MR. JAMES M. KELLY: Yes, they do.

The separation of the medical school from the hospital

effect on the quality of care given?

MR. JAMES M. KELLY: Yes, I think they

the effect on the quality of care given

the effect on the quality of care given

the effect on the quality of care given

the effect on the quality of care given



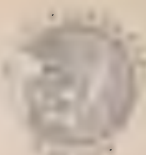
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MacCharles

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4 the field, then the medical practice of every individual  
5 that was participating was disclosed to the plan and  
6 was a matter of record. This would have some tendency  
7 to promote a little higher quality of medical care and  
8 a little better care in carrying out the performance  
9 of your medical practice.  
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the field, then the medical practice of every individual  
that was practicing was disclosed to the public and  
was a matter of record. This would have some tendency  
to produce a little higher quality of medical care and  
a little better care in carrying out the performance  
of your medical practice.

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It would eliminate a certain amount of undesirable type of practice, because merely by the fact their work was being scrutinized by somebody would stop a lot of it.

Then, the other thing is that a lot of the plans, and I think probably most of them, a record is kept of every patient's condition and of the things that are done for them. These patterns are reviewed and the ones out of line are closely scrutinized. Quite a few of them are quite normal for the particular doctor who is doing it, but there is a small core that require to be investigated. This is sometimes done and action of a disciplinary nature is taken. This is very seldom, the number is small, but it has happened. I am sure that the quality of medical care is definitely improved since the operation of the plans.

The other point that is rather important is that one of the great difficulties in medical practice is to get the patients to go early to see the doctor. This applies particularly in dealing with cancer, of course, and we found that the main reason why people delayed going to the doctor was the fear of the cost of it. That factor has been removed so people go early. That is one thing.

The next thing is that when they do go the doctor does not have the fear of running up a big medical bill and try to cut down on the investigation that should be done. This was a feature of the prepaid plan practice. That has been eliminated now and possibly it has swung the other way, they may go oftener than might be considered necessary by some. This, too, improves the



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It would be almost a complete record of all the work  
of practice, perhaps nearly by the fact that the work has  
being carried out in a somewhat haphazard way at the  
present time. The other thing is that the work is  
the result of the work of the past, and the work is  
kept of every patient's condition and of the things that  
are done for them. These patterns are revised and the  
ones that are at the time are slowly accumulated. (After a few  
of them are done, the pattern is not the same as it was  
before it, but there is a small change in the pattern to be  
investigated. This is something that is not done of  
discipline, but it is a very serious thing. This is very serious, and  
perhaps as well, but it is not a very serious thing. The  
the quality of medical care is definitely improved since  
the completion of the plan.

The other point that is of interest is that  
that is that one of the great difficulties in medical  
practice is to get the patient to go on to see the  
doctor. This is a very serious thing, and it is a very  
of course, and we found that the main reason why people  
delayed going to the doctor was the fact that the cost of  
it. That factor has been removed in the past. That  
is one thing.

The next thing is that when they go to  
the doctor, they find that the doctor is not doing up to  
medical standards, and they are not doing up to the  
standards of the past. This is a very serious thing, and  
it is a very serious thing. That has been a very serious thing  
and many of the things that are done are not done in a  
satisfactory way. This is a very serious thing, and it is a  
very serious thing.



MacCharles 9153

quality of medical practice; even if it costs more it is not a total loss because sometimes things are found quite early that can be taken care of with a minimal amount of trouble and expense to the patient and eliminates a serious illness and higher expense later on. I think in many ways, in all these and possibly some others that just do not come to my mind at the moment, the quality of practice has been improved.

DR. MacDOUGALL: May I add a comment on that? The ones that Dr. MacCharles mentioned are almost inherent in the fact that a doctor must report what he is doing, and the diagnosis of his patient and so on and, therefore, of necessity his method of practice is before his peers. It is inherent in this type of operation, he is scrutinized by his peers, but above and beyond that there are other duties which prepaid medical plans have instituted, some of them most positive. For instance, these are different, perhaps, throughout the country and we are representing eleven different plans, so some of the things I have to say will apply in one area but not in another. An excellent example, as you well know, Dr. Van Wart is in our own Province where the plan recommended to the medical society that only those qualified to read electrocardiograms would be paid for by the plan. It was up to the medical society to give a list of those qualified, not only to read, but to keep an accurate record and be able to produce them at any one time. This, I think, is evidence of a positive step that the plan was able to do, with the body that has the final control of the quality of medical care, the medical





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DR. MACDONALD: May I ask a question?

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medical society, the medical society, the medical



MacDougall 9154

profession.

I think there are many instances of that type across the country that the plan was able to recommend to the medical profession and thereby help, in a good way, to control the quality of medical care.

MR. SHILLINGTON: There is one point I feel should be added to this; I do not think it should be indicated on the record that the plans are the ones who handled the quality of care. The plans are nothing more or less than the arms of medicine, an extension of the profession and they represent only the mechanics by which the profession itself exercises these controls. I do not think any one of us would want it construed that the plan, as such, is the group who are exercising control by providing a facility.

COMMISSIONER VAN WART: I think Dr. MacDougall brought that out, the electrocardiogram was initiated from the medical society and they were asked that the plans just pay a certain list, that were presented to them from the medical society, who were capable of reading electrocardiograms. It was not the plans that initiated it, it was the medical society.

My last question is, what are your views on some sort of pooling arrangement for the hard to cover group? Have you any comment to make on that?

DR. MacDOUGALL: I would just say this may be accomplished through a syndicated arrangement with TCMP plans and mutualizing their losses. I think this can be a practical arrangement and could be worked out.



MacDougal 2154

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COMMISSIONER VAN WART: I think so.

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MacDougall 9155

COMMISSIONER McCUTCHEON: Would the  
TCMP plans do that on their own or do you want a wider  
pool?

DR. MacDOUGALL: I think we would be  
prepared to take our share.

THE CHAIRMAN: What is your share?

COMMISSIONER McCUTCHEON: Your share  
of premiums compared to the total in the health field?

DR. MacDOUGALL: We would be willing  
to take a bad risk in the groups or individuals which we  
have enrolled.

COMMISSIONER McCUTCHEON: What about  
the doctors' new policy and I go in and I am not in very  
good shape, would you take me?

DR. MacDOUGALL: We have recommended  
that for a plan.

COMMISSIONER McCUTCHEON: Then I just  
want to understand you, because I think you would get  
great support for what you are suggesting. The loss that  
you take on me, say, in P.S.I. would be prorated among  
the plans of TCMP plans, but then my friends and  
neighbours in the same state would come in and you would  
accept them and surely you would end up taking all the  
poor risks and leaving the commercial carriers with the  
good risks.

DR. MacDOUGALL: I trust we are taking  
this in the context of the recommendations that we have  
made within our brief?

COMMISSIONER McCUTCHEON: All I am  
asking you is, when you speak of a pooling or assigned





Mr. McLaughlin:

COMMISSIONER McLAUGHLIN: Would the

TCMP want to that on their own or do you want a wider

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accept them and surely you would end up taking all the

good risks and leaving the commercial carriers with the

bad risks.

DR. McLAUGHLIN: I trust we are taking

the in the context of the recommendations that we have

made with our belief.

COMMISSIONER McLAUGHLIN: All I am

asking you is, when you speak of a pooling of assets



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pooling, do you mean that to cover all carriers both the medical-sponsored TCMP carriers, other medical-sponsored carriers that may not be members of your group plus the commercial carriers whether they are mutual or not?

DR. MacCHARLES: I think we would quite obviously take a look at it with an open mind and go a little beyond halfway in meeting this thing. I think we should put this question in its proper perspective. It is important to realize we are relatively new in this field, in prepayment medicine. It is just a little over twenty years we have been in this field and when we started up, at that time we knew little or nothing about it. To make sure we were not getting too bad a licking on it we put in quite a few safeguards and we started out in a careful, maybe ultra-careful manner. As we acquired experience and volume and quite a little more willingness to accept a risk, we started taking off some of these safeguards. Now, this process has sometimes been pretty slow, sometimes it has been so slow that these safeguards came to be regarded by the profession not as something to be rid of, but something built right into the plan. When you try to talk a large number of men into a change of this nature there is a certain rate at which you can proceed without causing too much friction in bogging it down altogether and you must not extend that right. We have been rather slow in dropping some of these safeguards and some of the plans have been slower than others. In Manitoba they have thrown out all of these restrictions with one exception and the one exception is the waiting period for pregnancy. I think



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exception is the waiting period for pregnancy. I think





MacCharles 9157

that is in the process now of being eliminated, so any individual can go in and get a coverage there without any restrictions whatever, age, illness or anything else.

MR. SHILLINGTON: In the subject of this pooling arrangement there are some factors which have to be considered that I think we should mention. In an area where you have a physician-sponsored plan, take Alberta, for instance, where you only have one large plan covering everybody on a community rate base, there does not seem to be any great merit in their pooling arrangement there, because they are already charging the employed person something extra to cover the poor risk. In areas such as British Columbia where experience rating is a prevailing method then it seems more applicable and useful. As you are perhaps already familiar this matter is under active study with some process or method of cooperation in pooling. There are factors which limit it and I think that perhaps any approach to it would best be done within a Provincial base, in the first instance, in taking into consideration the other factors in that area.

COMMISSIONER FIRESTONE: Dr. MacCharles, I would like to say, first of all, that this is a very fine brief and I would like to congratulate you particularly on Chapter 4 which includes a number of projections as to specific proposals of how to implement a comprehensive and universally available medical care plan for Canada. It is very helpful to us.

I have some questions relating to these





Washington, D.C.

that is in the process now of being eliminated, or any individual can go in and get a coverage there without any restrictions whatever, age, illness or anything else.

MR. MILLER: In the subject of

this working arrangement there are some factors which have to be considered that I think we should mention. In an area where you have a physician-stored plan, such as Alaska, for instance, where you only have one large plan covering everybody on a community rate base, there does not seem to be any great merit in their pooling resources with others, because they are already charging the employee person something extra to cover the premium. In cases such as British Columbia where experience rating is a prevailing method then it seems more reasonable and wise. As you are perhaps already familiar with this matter is under active study with some proposals in mind of cooperation in pooling. There are factors which limit it and I think that perhaps any approach to it must first be done within a provincial base, in the first instance, in taking into consideration the other factors in that area.

I would like to say, first of all, that this is a very fine book and I would like to congratulate you particularly on Chapter 4 which includes a number of very interesting and useful statistics of how to implement a health plan and some really excellent medical data in the last part. It is very helpful to us. I have some questions relating to the



MacCharles 9158

future projections but, first of all, I would like to deal with two small questions. I do not know whether you have a general by-law of the TCMP, but I find that you set out in Paragraph 3 the membership of your Association and you include, and I quote:

"Membership in the Corporation is open to any corporation operating a prepaid non-profit medical care plan in the Dominion of Canada which plan is sponsored or approved by the division or divisions of the Canadian Medical Association ---"

And you also go on to say that one essential requirement is that these groups:

"Comply with such minimum standards for medical care plans ... that may be set from time to time."

Then you, in your regulations you have set out these minimum standards. Now, have you had any difficulties among your members in maintaining those standards which are set out in your regulations?

DR. MacCHARLES: I do not think so, I have not been aware of any.

COMMISSIONER FIRESTONE: Have you had any applications for membership from groups of people who did not comply with those minimal standards?

DR. MacCHARLES: Prepayment plan?

COMMISSIONER FIRESTONE: Yes.

DR. MacCHARLES: No, sir, we hoped we would have some, but we have not got them yet.

COMMISSIONER FIRESTONE: So you feel



For the purpose of this, I am sure that  
 you have a general knowledge of the TWP, and I think that  
 you are out in paragraph 3 the membership of your

association and you are not, and I cannot

be sure if the corporation is open to

any corporation operating a business

specific business, can plan in the business

in this which plan is sponsored on approved

by the division or divisions of the Department

of the Department --"

and you also go on to say that one

essential requirement is that these groups

be closely with such financial standards as

financial soundness, etc., that may be set down

time to time."

Then you, in your regulations you

have set out these financial standards, now, have you had

any difficulties arising from having to maintain these

standards which are not set in your regulations?

Mr. Chairman: I do not think so.

I have not had a word of any.

Mr. Chairman: Now, have you had

any difficulties for maintaining from groups of people who

are not really with these financial standards?

Mr. Chairman: Now, Mr. Chairman, we

would have some, but we have a lot of them.

Mr. Chairman: I am not sure if you



MacCharles 9159

that these minimum standards have generally been acceptable to the insurance industry as far as the voluntary non-profit plans are concerned, those that have applied for membership?

DR. MacCHARLES: Yes, sir.

COMMISSIONER FIRESTONE: Thank you.

My next question relates to some comments which Mr. Shillington made a little earlier when speaking of cancellation. I am just wondering if I understood you correctly and if I do not, then please correct me. Mr. Shillington, you were saying that one of the principles of writing these policies is to maintain coverage for subscribers as long as they live; that is a principle that you are aiming at?

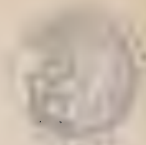
MR. SHILLINGTON: That is right.

COMMISSIONER FIRESTONE: Well, would you say from your knowledge of how the various plans that are members of the Trans-Canada group arrangement, would you say that there have been a number of cases where conditions have changed and where it was found necessary to raise the premium because of a change in condition? Have you had any experience with such cases?

MR. SHILLINGTON: That is right, I think that premiums increase over the years and that has been a regular part of the growth and progress of the plans.

COMMISSIONER FIRESTONE: If I may perhaps supplement this question by referring to it more specifically, to an individual whose health condition has changed who may have had some more sickness than he





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that these various agencies have generally been successful  
to the satisfaction of the public and the industry  
and it is our opinion, that they have been successful  
in their work.

My next question relates to some comments which Mr.  
Hill has made a little while ago regarding the  
industry. I am not sure if I understood him correctly  
and I am not sure, but please correct me. Mr. Hill  
you were saying that one of the principles of  
the industry is to provide coverage for subscribers  
as long as they live; that is a principle which you are  
aiming at?

Mr. Hill: That is right.  
Mr. Hill: That is right.  
You say from your knowledge of the various plans that

you say that there are some 10 million of these plans  
and that they are all in the hands of the public and  
to make the public aware of the plans is our aim.  
Now, you say that the public is not aware of the plans.

Mr. Hill: That is right.  
I think that the public is not aware of the plans and that  
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the industry is to provide coverage for subscribers  
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aiming at?



Shillington 9160

used to have and whose sickness is above the average and the insurance corporation would say, "I am sorry, you have had more sickness and now that we are coming to the renewal of the plan you have to pay a higher premium". I am referring not to the group plan but to an individual plan.

MR. SHILLINGTON: My experience is that I would say no. I am aware that there have been isolated instances, in one or two places where they have sought to reduce or get a subscriber back on the right track, so to speak, where they perhaps have reduced office calls for a certain period. However, these are isolated things that have been necessary and they have generally been frowned upon. I think over the years I would say no as a general answer.

COMMISSIONER FIRESTONE: Do you know of any cases where a worsening of a health condition would specifically involve either exempting this particular health condition or raising the premium specifically? Let me give you a concrete example; say somebody all of a sudden developed a heart condition and he would then receive a letter which says that any calls for a treatment connected with this condition is exempted after the expiry of the contract or in view of him being an increased risk the premium would be higher.

MR. SHILLINGTON: It is not a general policy at all.

COMMISSIONER FIRESTONE: I know it is not general policy, I am just inquiring whether you have had complaints of cases of this order?

MR. SHILLINGTON: As I have said



SHILLINGTON: Yes.

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would say no as a general answer.

COMMISSIONER TINSLEY: Do you know

of any cases where a lowering of a health condition would  
effectively involve either exempting this particular  
health condition or raising the premium specifically?  
Let me give you a concrete example; say somebody all of  
a sudden developed a heart condition and he would then  
receive a lot of calls that any calls for a test-  
ment connected with this condition is exempted after  
the nature of the contract in view of him being an  
insured with the premium would be higher.

MR. SHILLINGTON: It is not a general

policy is all.

COMMISSIONER TINSLEY: I know it is

not general policy, I am just inquiring whether you have

an exemption of cases of this kind?

MR. SHILLINGTON: As I have said



Shillington 9161

earlier, there were isolated examples and this was attempted as an example. My own Province of Saskatchewan where I was associated with a plan for many years, as an experiment in the years gone by this was tried, but I think over the years it was a limited effort and gave way in due course to what was considered better judgment. To the best of my knowledge this is just not so.

DR. MacCHARLES: This just happens in experience rating of groups, when a group has a bad experience I believe the plans where the experienced groups in the early days, some of these individuals instead of being covered on a comprehensive plan would be put on a partial plan. I have never heard of one being cancelled because he was using it legitimately so much, this is the last thing we would want.





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...corrected because he was using it legitimately so much.  
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MacCharles

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COMMISSIONER FIRESTONE: Thank you.

But you see, sir, even transferring a person may be disastrous if that person were of moderate circumstances. Are you saying that these transfers take place? Are they continuing to take place?

DR. MacCHARLES: I know of one that took place and it happened to be a parson, a preacher, and his expenses were quite legitimate, and we can assure you as far as the Manitoba plan is concerned, it has never been done since. It was 15 years ago.

COMMISSIONER FIRESTONE: In other words, these were isolated cases?

DR. MacCHARLES: Yes.

COMMISSIONER FIRESTONE: What you are saying is that these are isolated circumstances but this is not the general policy of the plan now; is that correct, sir?

DR. MacCHARLES: That is absolutely correct.

DR. MacDOUGALL: May I add, Professor Firestone, that coverage is not individually underwritten and therefore it would not be a policy; and, secondly, I would like to state now that never in the history of our plan has this happened, and I would be surprised to hear of even isolated instances.

COMMISSIONER FIRESTONE: When you are referring to "our plan", what plan is that?

DR. MacDOUGALL: New Brunswick.

COMMISSIONER FIRESTONE: Well, I am reassured, Dr. MacCharles, and while you are saying some





MacCharles

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such cases may have taken place in the past, that is not the policy of your participating members.

DR. MacCHARLES: That is correct. In fact, the policy is not to do it.

COMMISSIONER FIRESTONE: Then I am reassured; I am very happy with this information. Now, may I come back to the specific and helpful suggestion you have made about future coverage. You speak in paragraph 8 of your summary about the hard core group for whom the task of providing coverage is difficult and the results somewhat unspectacular.

Included here are the aged, the unemployed, the part-time workers, and others in the low income group; and in paragraph 148 you feel medical care services for these groups could be provided, and I take it the essence of your proposals, without wanting to go into details because your Chapter IV speaks for itself - but without wanting to go into details, as I understand it, the main suggestion is that these are people that can only pay for the medical care services, the premiums that are required, either in part or not at all, and therefore the difference should be made up by the State.

Am I correct in that basic understanding of your proposal?

DR. MacCHARLES: Yes, sir.

COMMISSIONER FIRESTONE: When we speak of the State, I take it you have in mind, in the first instance, the Provincial Government, which has a major responsibility in the health field. Do you visualize a national plan under which the Federal Government may make





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at least have been taken place in the past, and not  
the rest of your participating members.

Q. Now, what is the company, in

fact, that is now in the field?

A. The company is now in the field.

reassured; I am very happy with this information. Now,  
may I come back to the question of the hospital situation  
you have made about future coverage. You speak in  
Paragraph V of your statement about the need for a group  
too when the task of providing coverage is difficult and

needed here are the aged, the young

oldest, the part-time workers, and others in the low  
income group; and in Paragraph IV you feel a special case  
services for these groups could be provided, and I take  
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into details, is that Chapter IV speaks for itself -  
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Am I correct in that basic understanding?

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A. Yes, sir.

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rest of the field. Do you think a  
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MacCharles

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a financial contribution to provinces to implement such objectives as you state in Chapter IV?

DR. MacCHARLES: Yes. I don't know what you mean precisely by "a national plan". Do you mean a plan in which the Federal Government makes grants to the provinces and gives them legislation to enable them to do it?

COMMISSIONER FIRESTONE: Well, we have, in the field of hospital insurance, a national plan which provides certain financial assistance to the provinces to introduce hospital insurance and other related services, allowing a certain flexibility, because some provinces wish to do it one way and other provinces wish to do it another way. It is in this context that the question is raised.

DR. MacCHARLES: The answer is yes.

COMMISSIONER FIRESTONE: Would you be supporting a "national plan" in the sense we have been discussing, which followed the principle embodied in the hospital insurance program?

THE CHAIRMAN: Of course, the doctor won't know what the principles are. You mean the principle as to federal contribution to a provincially-operated plan?

DR. MacCHARLES: Yes.

COMMISSIONER FIRESTONE: That is quite correct. This is one of the principles. There are a number of others, and I didn't want to go over the complete hospital insurance plan; I think you are familiar with it, and I take it your answer is the principles would



Chairman

a financial contribution to provide to implement such objectives as you state in Chapter 1?  
Mr. MacGILL: Yes, I don't know what you mean precisely by "a national plan". To you mean a plan in which the Federal Government makes grants to the provinces and gives them legislation to enable them to do it?

COMMISSIONER: Well, we have, in the field of hospital insurance, a national plan which provides certain financial assistance to the provinces to introduce hospital insurance and other related services, allowing a certain flexibility, because some provinces wish to do it one way and other provinces wish to do it another way. It is in the context that the question is raised.

Mr. MacGILL: The answer is yes.  
COMMISSIONER: Would you be supporting a "national plan" in the sense we have been discussing, which followed the principle enunciated in the hospital insurance program?  
Mr. MacGILL: Of course, the doctor

won't know what the principles are. You know the principle as to Federal contribution to a provincial hospital program.

COMMISSIONER: That is quite correct. This is one of the principles. I am not a member of either, but I don't want to go over the complete hospital insurance act. I think you are familiar with it, and I think it would be the principles would





MacCharles

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obviously have to be applied somewhat differently in a medical care plan than in a hospital plan and, therefore, I can only deal with principles and not the details of the actual program.

DR. MacCHARLES: The answer is yes, sir.

DR. MacDOUGALL: May I add to that as a citizen, not as a doctor?

COMMISSIONER FIRESTONE: Yes.

DR. MacDOUGALL: Providing the province is in a position to accept this gift.

COMMISSIONER FIRESTONE: Well, as you appreciate, sir, this is permissive legislation; it is up to each province to make their own decision in their own wisdom, and I take it your answer is in that context?

DR. MacDOUGALL: That is the context.

COMMISSIONER FIRESTONE: Thank you very much.

Now, sir, I go on, if I may, and now turn Dr. MacCharles, to paragraph 10 on page iv, where you speak of coverage through existing voluntary care. Now, you are saying that you would hope that such a program as you have suggested in your Chapter IV could be implemented as stated in paragraph 10, sub-paragraph (2) on page iv of your Summary, and I quote:

"Coverage to such persons should be provided through the facilities of the existing voluntary agencies."

Now, let us assume, sir, that a provincial government accepts financial assistance from a federal government and succeeds in developing a provincial





...have to be applied somewhat differently in a  
medical care than in a hospital plan and, therefore,  
I can only deal with hospitals and not the hospital of

DR. MEDBURGH: The answer is yes, sir.  
DR. MEDBURGH: Now I add to that as a  
citizen, not as a doctor.

DR. MEDBURGH: Providing any province  
is in a position to accept this gift.

COMMISSIONER: Well, as you  
appreciate, sir, this is not passive legislation; it is  
in no sense a decision to have their own decision in which  
own decision, and I think the answer is in that context.  
DR. MEDBURGH: That is the context.  
COMMISSIONER: That is the context. Thank you very

much.  
Now, sir, I go on, if I may, and now turn  
Dr. Medburgh, to question IV on page IV, where you

you are saying that you would hope that such a program  
as you have suggested in your Chapter IV could be imple-  
mented as a state in paragraph 10, and paragraph 11 on  
page 10 of your summary, and I quote:

"...to some extent as a state in  
provided through the activities of the  
...as a voluntary association."  
Now, that is correct, sir, that is correct.  
...that is correct, sir, that is correct.  
...that is correct, sir, that is correct.



MacCharles 9166

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4 plan. Now, it will require an agency to administer that  
5 provincial plan. I take it that this suggestion of yours  
6 is that it would be preferable if each provincial govern-  
7 ment that proposes to proceed with such a plan were to  
8 use the existing voluntary machinery that existed already  
9 in each province?

10 DR. MacCHARLES: That was our hope for  
11 20 years.

12 COMMISSIONER FIRESTONE: Well, it is a  
13 constructive proposal. What do you do in the Province  
14 of Ontario where you have close to 40 organizations  
15 providing that sort of service?

16 DR. MacCHARLES: Well, I think maybe  
17 I will hand that to my friend, Dr. Lockhart. He is more  
18 familiar with Ontario than I am.

19 COMMISSIONER McCUTCHEON: While Dr.  
20 Lockhart thinks about his answer, may I ask another  
21 question, Dr. MacCharles? What do you do with the 117  
22 commercial carriers that are operating in the health  
23 insurance field?

24 DR. MacCHARLES: What would I do with  
25 them?

26 COMMISSIONER McCUTCHEON: Yes, in the  
27 context of Dr. Firestone's question.

28 DR. MacCHARLES: I don't know all these  
29 answers, sir, but my own thinking would be when government  
30 is contributing - I am speaking of the low income people  
here who require assistance - I would be surprised if the  
Government were willing to contribute to any other than  
non-profit operations.



...and ...

...that was our hope for

...it is a

...that do you do in the province

of Ontario where you have close to 40 organizations

providing that sort of service?

Dr. Macdonald: Well, I think maybe

I would have had to go through the ... do it was

related with ... that I was

I don't think about the answer, but I ask another

question, Dr. Macdonald: What do you do with the ...

commercial ... that are ... the ...

Dr. Macdonald: ... I would

... in the

... of the ...

Dr. Macdonald: I don't know ...

... and ... would be ...

... I am ... of the ...

... and ... in the ...

... and ... to the ...

... of the ...



MacDougall

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COMMISSIONER McCUTCHEON: What would you call the Metropolitan Life Insurance Company? As I understand it, it is the largest non-profit organization in the world - outside of the League of Nations.

DR. MacDOUGALL: May I be permitted to say a word on that one? Here, of course, you are getting us on an individual opinion because it is assuming and somewhat hypothetical. But I believe commercial insurance companies, if they followed in line with the recommendations we are recommending here, there would be nothing, T.C.M.P. would have no complaint whatsoever if the Federal Government or Provincial Government wished to work through a commercial insurance coverage. I would draw your attention, however, to the requirements that are laid down in 10 which Professor Firestone was quoting here:

"For that section of the population requiring financial assistance service benefits should be applied, in co-operation with the physicians as providers of service."

If they are permitted to do that, that would be fine.

COMMISSIONER McCUTCHEON: In other words, if the physicians would co-operate you would have no fundamental objection to these commercial carriers giving these same benefits being included?

DR. MacDOUGALL: None whatsoever.

DR. LOCKHART: I think if this hypothetical question were presented to the doctors of Ontario,





undoubtedly, it is the largest non-profit organization

in the world - a matter of fact, it is the largest

of its kind in the world.

Now, as to the fact that it is a non-profit organization, you will find

as an individual, it is a non-profit organization

somewhat like the others, but it is a non-profit organization

companies, it is the only one in the world that is

times we see a non-profit organization, there is no profit.

T.C.M.S. which has no corporate status in the

Federal Government or any other Government, it is

work through a commercial organization, it would

draw your attention, however, to the fact that it

are laid down in the law, and it is a non-profit

here:

"For the purpose of the organization

regarding financial matters, it is

service provided to the public, it is

in co-operation with the public, it is

as provided in the law, it is

it is and is intended to be, it is

would be like

it is intended to be, it is

if the organization is not a non-profit organization, it would be

fundamental objection to the organization, it is

these same principles, it is

it is, it is, it is

it is, it is, it is

it is, it is, it is



Lockhart

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in line with what I said this morning, I think an answer would very definitely be worked on and found, compatible with our principles, and we would certainly find an answer.

DR. MacCHARLES: I would like to add to that, sir, that in the whole field of medical prepayment there is no problem that can't be solved if given reasonable time. You can bring the profession along at a certain rate, you can't exceed a certain rate, but in time things can all be worked out.

COMMISSIONER FIRESTONE: Dr. MacCharles, and your associates, you are quite right something can be worked out with time, and I am not suggesting that time is running out, but there are increasing demands for a comprehensive program, and some of them are quite vociferous.

Here you have proposed some solutions, and all I would like to get from you is how the recommendations you have here can be implemented and so we can say: "Now, here is what these Trans-Canada Plan people have told us, but we are coming to you for this advice."

Now, I come back to what you say in paragraph 10, sub-paragraph (2), that you would like to see coverage for such persons, and they are defined in paragraph 8, should be provided through facilities of the existing voluntary agencies, I mean agencies such as members of your own group.





PB/hm 1

MacCharles

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DR. MacCHARLES: That is right.

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COMMISSIONER FIRESTONE: The problem you face only in the provinces where there are a great number. If you only have one agency in a province then it is easy for the Provincial Government to go to the agency and say will you be the administrating agency and the problem is solved. What do you do in a province like Ontario where you have got many and if the Government chooses one there are going to be several dozen that won't like it and if they choose another there will be others that may not like it. What do you do?

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DR. MacCHARLES: Sir, one thing that is important in this context, these are service benefits we are giving.

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COMMISSIONER FIRESTONE: Yes.

DR. MacCHARLES: I think the number that there may be that would be offering service benefits would be very restricted.

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COMMISSIONER FIRESTONE: Would you visualize that those that are in a position to provide these service benefits would get together and form a group so that they could be the negotiating or administrating agency with the provincial government or the provincial government could deal with one group instead of many. Is that the sort of arrangement you could visualize?

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DR. MacCHARLES:- I can visualize it. I think that would be possible.

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DR. MacDOUGALL: I would go a little







MacDougall

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4 stronger than Dr. MacCharles on that, Professor Firestone,  
5 and say this, providing it was shown to the profession  
6 this was in the interest of the patient or the  
7 subscriber, that it adhered to the principles of the  
8 Medical Association, which you are familiar with, and  
9 which are laid down, and which would be required to  
10 provide the services, and those receiving the services,  
11 there would be no reason why this voluntary organization  
12 could not and should not get together and be able to  
13 provide under one cover for these people.

14 COMMISSIONER FIRESTONE: All right.

15 MR. SHELLINGTON: One further point:  
16 This would, I think, be predicated on the licensing of  
17 standards of accreditation operating in the Province. I  
18 think in any province this would be from the beginning  
19 so that all carriers who are going to do this would  
20 meet certain levels. I think all people interested in  
21 this field, whether they are so-called non-profit  
22 insurers or whatever they may be, that the carriers who  
23 are sincerely interested in this would be quite prepared  
24 to accept some standard of accreditation, with a known  
25 staff working together in association or syndicate. I  
26 think this is purely a matter of administration which  
27 could be handled without any difficulty.

28 COMMISSIONER FIRESTONE: In other words  
29 you visualize, if I understand your suggestion correctly  
30 one group of the interested carriers that would combine  
into one organization of an umbrella type and look after  
this problem and be one body dealing with the Ontario  
Government. Is that what you visualize?





MacDougall

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DR. MacDOUGALL: Working together.

COMMISSIONER FIRESTONE: What this would really mean would be the equivalent in Ontario of an organization like Trans Canada Plans?

DR. MacDOUGALL: That is right.

COMMISSIONER FIRESTONE: Because you have this, you have accreditation?

DR. MacDOUGALL: It would be an Ontario organization. Perhaps we had better not have Trans Canada Plans. There would be several plans who would not like the name. It would be an association of interested plans by approved accreditation.

COMMISSIONER FIRESTONE: If I may make myself clear, I didn't suggest this organization in Ontario would use Trans Canada's name, but it would follow the same principle and adopt the organization and pattern that you have followed.

DR. MacDOUGALL: That is right.

COMMISSIONER FIRESTONE: Because in order to make arrangements with the Provincial Government you need a provincial group.

DR. MacDOUGALL: That is correct.

COMMISSIONER FIRESTONE: If such a provincial group came into existence it would have a Board of Directors in the government body?

THE CHAIRMAN: Are you stating that, laying that down as the law, you would have to have a provincial group?

COMMISSIONER FIRESTONE: I have been enquiring ....







MacDougall

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4 THE CHAIRMAN: You are postulating.  
5 I want to understand the answer that is given if it is  
6 to be of any help to me as a Commissioner and to the  
7 others.

8 COMMISSIONER FIRESTONE: Mr. Chairman,  
9 we have been receiving answers from Dr. MacCharles and  
10 his associates.

11 THE CHAIRMAN: I have heard everything  
12 he said. I think I have understood it, but you are  
13 now postulating the proposition that you must have a  
14 provincial organization?

15 COMMISSIONER FIRESTONE: Well, Dr.  
16 MacCharles, my question relates to a provincial organiza-  
17 tion that would carry on a sort of discussions with  
18 the provincial government. We have received an answer  
19 from you that you would visualize an organization built  
20 along the pattern of Trans Canada Plans?

21 DR. MacCHARLES: That is right.

22 COMMISSIONER FIRESTONE: Now, how do  
23 you make policy decisions in Trans Canada? Have you got  
24 a Board?

25 DR. MacCHARLES: We have a Board. We  
26 have eleven member plans and the Ontario Medical  
27 Association are also a member of the T.C.M.P. and each  
28 appoints two representatives, so we have 24 people.

29 COMMISSIONER FIRESTONE: Have you got  
30 lay representation?

DR. MacCHARLES: Yes, there are quite  
a few lay representatives.

COMMISSIONER FIRESTONE: What division





MacCharles

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3 between lay representatives and medical, professional  
4 representatives?

5 DR. MacCHARLES: The medical profession  
6 in T.C.M.P. would predominate because two from C.M.A.  
7 are medical -- one is medical and presumably there is  
8 one medical from each of the member plans. There is  
9 occasionally another doctor thrown in so it would  
10 predominate. It is important for you to realize, sir,  
11 that T.C.M.P. is not a company doing business. We are  
12 not in underwriting. We are more like a trade  
13 organization. One of our difficulties has been we have  
14 to have unanimity. We cannot work on a majority, do  
15 business on a majority rule. In other words we have  
16 been given certain responsibility, but we have not been  
17 give comparable authority, so we have been restricted  
18 in our effectiveness for that reason. The organization  
19 you visualize would have to have a slightly different  
20 set-up in that regard.

21 COMMISSIONER FIRESTONE: Dr. MacCharles,  
22 you are really reading my mind. I am turing to you  
23 for advice based on your experience. Can you make a  
24 suggestion to us as to what kind of an organization would  
25 be more effective in the context of the question we  
26 have been discussing on a provincial basis because the  
27 insurance would be carried on behalf of a provincial  
28 group and the Provincial Government, and therefore, I  
29 am coming to you for advice based on your experience.  
30 If you are not in a position to offer advice then say  
so. If you can it would help.

DR. MacCHARLES: I hesitate to offer you







MacCharles

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4 advice on this, sir. I would like to point out to  
5 you our friends across the border have had the problems  
6 we have had, far more because they are more complicated.  
7 They have more people and more organizations, but this  
8 year they are changing their constitution of their  
9 Blue Shield plans. Originally all the Blue Shield  
10 plans had State autonomy, autonomy within their own  
11 field of operation. When they came to the central  
12 organization in Chicago they maintained it. Now they  
13 are changing their constitution so the Blue Shield  
14 organizations, the State plans will maintain their  
15 autonomy within their own field, but in dealing with  
16 national contracts the authority is to be centralized  
17 in the central office. This sort of organization,  
18 something parallel would be required similarly in a  
19 provincial set-up, I would think.

20 COMMISSIONER FIRESTONE: Dr. MacCharles,  
21 you have been very constructive both in your brief  
22 and your answers, that applies to you and your associates.  
23 Thank you very much.

24 THE CHAIRMAN: Thank you very much,  
25 gentlemen. We will go on to the next one, the Associated  
26 Medical Services Incorporated. Dr. Hannah?

27 THE SECRETARY: The submission will  
28 be known at Exhibit 246, sir, and the appendix thereto  
29 as 246A.

30 ---EXHIBIT NO. 246: Submission of Associated  
Medical Services Incorporated

---EXHIBIT NO. 246A; Appendix to submission of  
Associated Medical Services  
Incorporated.





SUBMISSION OF  
ASSOCIATED MEDICAL SERVICES INCORPORATED

APPEARANCES: Dr. J. A. Hannah  
Dr. J. G. Palmer  
Dr. W. W. Wigle

DR. HANNAH: Mr. Chairman, Commissioners,  
I would like to take this opportunity of expressing our  
appreciation for the privilege of appearing before you.

Our concept of what we put in our  
brief seems to deviate a little bit from the concept I  
have obtained.

THE CHAIRMAN: Would you like to sit  
down, Dr. Hannah?

DR. HANNAH: I should introduce my  
colleagues: Dr. Palmer, our chief medical advisor and  
Dr. W. W. Wigle, our medical director. I am Dr. J. A.  
Hannah, managing director of Associated Medical Services.

As I was saying our concept when we  
started out was that we were dealing with the problem  
of the health needs generally of the population of Canada  
and Ontario particularly. My impression of what I have  
seen today is that we seem to be dealing with what type  
of government controlled plan will be instituted.

THE CHAIRMAN: I am sorry that you got  
that impression, Dr. Hannah. If you read our terms of  
reference you will not find it so expressed.

DR. HANNAH: This I appreciate, Mr.  
Chairman.

THE CHAIRMAN: If some questions you have







Hannah

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4 heard gave that indication they are not intended in  
5 that sense. The questions, and I have said this on a  
6 number of occasions throughout Canada, that questions  
7 will be asked which are provocative, which may have one  
8 meaning or another and people will be very much in error  
9 when they try to read conclusions into questions.  
10 Therefore, don't temper your arguments to the, shall we  
11 say, the shorn or the unshorn questions. You are on  
12 your own.

13 DR. HANNAH: Thank you, sir. With  
14 that introduction, sir, I would like to read our  
15 conclusions and our recommendations, if I may.  
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Hannah

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CONCLUSIONS

Thirty years of study and twenty-five years experience in actually providing a means of "prepayment for the cost of medical care" have led us to certain conclusions, some of which we set out below:-

a) Progress is possible only through education and by evolution. This is particularly true in the medical care field.

Progress in the science and therapeutics of medical care has been reasonably satisfactory and accelerating very rapidly during the past half century. This has come about through evolution which in turn is only possible through the dissemination of knowledge to the "grass root" masses, and progress can only come as fast as the roots can absorb it. Developments can be guided, but not forced from the top down.

b) There are a number of mistaken, over-exuberant concepts in regard to health itself, and the provision of medical care, which are dangerous and incompatible with the possibility of real progress.

Some of them are:-

i) Health is not just absence of disease but a positive feeling of well-being and is attainable by everyone.

ii) Prepayment for the cost of illness is possible through insurance and can be sold or bought in "bundles" like match sticks.

iii) Good health and medical care can be







Hannah

9178

secured if only we are prepared to  
spend enough money for it.

While it would be foolish to become  
passive in respect of any of these and many other  
factors, it is not only foolish but dangerous to be  
deluded by over-enthusiasm in respect of any or all of  
them. Without denying the necessity for adequate finances  
in all respects, money alone cannot buy good or adequate  
health services; or pay for the cost of illness. Rather  
the primary consideration must be; dedicated, well-  
trained, sound personnel. This type of personnel,  
although of necessity interested in financing themselves,  
is more interested in the personal satisfaction of  
accomplishment and service than piling up money. Too  
much money may destroy the elements which give rise to  
these satisfactions. Too much money is interfering with  
the proper and efficient use of hospital accommodation  
at the present time.

c). Time is required for sound growth  
and development. To attempt to bring about changes  
"overnight" will incorporate the elements of mistakes  
through ignorance. It will develop improper concepts  
about the project as a whole and through lack of  
training of staff will establish rule by regulation and  
destroy the desire to improve either the concepts or the  
methods under which the scheme can operate successfully.

d). The most basic requisite is to get  
the medical profession to recognize that it is the price  
of the peculiar privileges which they enjoy, that they  
must accept their corporate and individual personal





Hannah

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responsibility in making and keeping the total field of medical care self-sustaining and solvent. This is possible and has been done in a few instances. Until this possibility is recognized and accepted by the various bodies concerned, we will continue to seek in vain for a solution and will continue to establish special committees and Royal Commissions at intervals of approximately 20 years (provincial or federal) to study the health and medical requirements, cost and otherwise, of our population and a means of providing them.

THE CHAIRMAN: I suppose 20 years is often enough for you, Dr. Hannah?

DR. HANNAH: Too often, sir.

e) Canada has been well represented in the forefront of all spheres of medical advances. To name but a few internationally known Canadian figures in the respective fields: In psychiatry - Workman, Metcalfe, Clark and Hincks; In therapeutics - Sir William Osler and Allan Brown; In surgery - Roscoe Graham, E.D. Gallie, Wilder Penfield and Cone; In preventive medicine and hygiene - Fitzgerald, who gave us the Connaught Laboratories, and Hastings; In research - Banting, Best and Tisdale. No doubt other names could be chosen and the list could be extended very materially.

f) "Prepayment for the cost of medical care" is a unique development in solving the problem of medical economics and had its origin in Ontario in co-operation with the medical profession. It has spread and has been, and is continuing, to be developed in co-operation with the medical profession throughout







Hannah

9180

Canada as a whole. This has been done without cost to Government, and by voluntary donation of ability, time, energy and expense, which could not have been purchased by anybody, Government or otherwise. We are unaware of any parallel situation. In our opinion, the encouragement of further development along these lines would give the most satisfactory results, and save Canada millions of dollars annually.

g) The leadership displayed in the fields as set out in (e) and (f) above has been equalled by the individual members of the profession in bringing a high quality of medical and health care to the population of Ontario, and Canada as a whole.

h) These developments have come about under, and because of, the freedom with which members of the profession have been able to deal with the problems presented in each of the various fields.

i) Attempts to hasten developments by legislative or other means will retard advances, cause a deterioration in the quality of research and medical care and will give rise to spiralling costs.

j) Apart from a few areas of the application of general health control measures, such as quarantine, pasteurization of milk, treatment of water supply and other general, broad health and sanitation measures, it is an error, based on impatient wishful thinking to presume that the field of medical and health care can be forced, either in the matter of acceptance, by the public and the profession; or, on the other hand, in quality and quantity of the services brought to the public.





Hannah

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4 There is a rather broad area in which co-operation is  
5 possible. This, if kept as co-operation, will help to  
6 continue advances made, particularly during the past  
7 half century as shown by the Dominion Bureau of Statis-  
8 tics. On the other hand, there is another area in which  
9 the best possible co-operation is to leave the care of  
10 the sick individual to the very personal relationship  
11 between the patient and his doctor.

12 k) The problem of medical economics  
13 is solvable under the application of the Insurance  
14 Principle only, and we repeat ONLY, if and when it is  
15 intimately and closely linked with the co-operation of  
16 each individual doctor. Inevitably, the problem of  
17 "necessary" must be considered; first, at the bedside  
18 of the sick patient and, secondly, when the bill is to  
19 be paid. Only the doctor in immediate bedside association  
20 in charge of the case, who has (or is presumed to have)  
21 saved the patient from more serious developments or from  
22 death itself, can determine what is necessary either by  
23 way of treatment or payment for services rendered. Under  
24 such a relationship, the judgment of the doctor will be  
25 accepted by the patient in the vast majority of cases.  
26 However, even then, in the matter of payment of the  
27 account by a third party such as an insurance company,  
28 the doctor's judgment will not be readily accepted by  
29 the patient if it affects his "purse" too greatly. Under  
30 such circumstances, the doctor is placed in an untenable  
position and it becomes very difficult for him to do  
other than "side" with his patient. If he does otherwise,  
he will lose both his patient and a well-earned fee.







Hannah

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Since the doctor is not primarily concerned with the economic success of insurance, but very much concerned with his patient's as well as his own economic situation, it is only reasonable that he will favour the desires of his patient rather than the solvency of an "insurance fund", whether it be Government-controlled, non-profit, or private profit-making enterprise. Therefore, the successful operation of "insurance" in sickness becomes dependent upon the doctor.

l) Twenty-five years of experience confirms not only the above conclusions but that if the doctor feels that he has an intimate and direct association with the economic as well as the health needs of his patient; or, if he has a responsibility for the "prepayment" principle, the vast majority will give due consideration to the solvency of his own and his patient's economic welfare through their common prepayment fund. Thus "prepayment for the cost of medical care" has the necessary element of protection of the common fund which is lacking in "Health Insurance".

m) Given proper co-operation and support, we are convinced that the medical profession can continue the developments started through their approved or sponsored plans, and within the next ten to twenty years can produce a self-sustaining system of "prepayment for the cost of medical care" and, in so doing, will be able to continue the high quality of medical care and leadership now existing. At the same time, Canada will be saved millions of dollars annually.

n) The cost of medical care is high,







Hannah

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3 and must remain so if we are to have the type of care  
4 we all hope to get if we or one of our family fall ill.  
5 We have endeavoured to show why such must remain the  
6 case by setting out particulars in regard to the cost  
7 of educating and training a doctor. There are many  
8 other areas of necessary high costs which could be  
9 delineated and which will continue to keep medical care  
10 costs high. On the other hand, there are undoubtedly  
11 many areas in which costs could be materially reduced,  
12 e.g. extravagancies in design and construction; extra-  
13 vagant repetitions in diagnostic procedures; extravagant  
14 methods of practice; the extravagance of too large,  
15 centralized hospitals, etc., etc.

16 o) These, however, are factors which  
17 cannot be eliminated through compulsory legislation.  
18 They will yield only to study, appreciation and under-  
19 standing by everyone of all the problems involved. In  
20 the long run, it will be more satisfactory and much less  
21 costly if the problem is approached through evolution  
22 and education. Legislation tends to "freeze" what is  
23 thought to be the best of the moment into tomorrow's  
24 continuing pattern; whereas today's "best" must be only  
25 the beginning of tomorrow's "better". This must remain  
26 the pattern of freedom to which democracy as a whole  
27 must aspire if it is to continue. It is the only tolerable  
28 and possible basis for providing the best medical and  
29 health care for the people of Canada.

30 p) Although the cost of medical care  
must remain high, the ratio of increase for doctors'  
services has not advanced out of proportion with other







Hannah

9184

necessities in life. Indeed the increase in the cost of luxury items and wage earnings in general have exceeded the advances in doctors' charges. Certainly the money expended on cigarettes, alcohol, cosmetics, etc., etc., far exceeds the cost of doctors' services. These, however, do not become an economic or political issue because, although they are not essential to life or even health, they are "pleasure" items. On the other hand, the more a doctor's services become essential, the less pleasant the experience involved, and hence the unreasonable "hue and cry" against costs.

q) If we are to maintain and improve the high quality of medical care at present enjoyed by Canadians, we must immediately give consideration to attracting to the medical profession more students of outstanding character and ability. Since the financial outlook for the individual doctor is limited, and the cost of entering this "calling" is unavoidably high, anything which detracts from other types of satisfaction will inevitably deter suitable prospects from entering the medical course and result in a shortage of personnel, and eventually degeneration of medical care.

r) Apart from the heavy expense involved, one of the already existing deterrents to choosing medicine as a career is the long period of training before the student becomes self-supporting. It is not proposed that the actual training can be shortened, but the number of years required could be shortened by extending the teaching term from 32 to 45 weeks in the year. In addition to getting the medical student into productive





Hannah

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4 earning, this would make more efficient use of capital  
5 investment and reduce the overall cost of training by  
6 a very considerable sum of money. Adoption of such a  
7 program would have the added advantage that it could be  
8 made operative almost immediately since the buildings and  
9 equipment are already in existence.

10 The prerequisite for advancing good  
11 medical care in Canada is freedom; freedom for the patient  
12 to choose his physician and vice versa; freedom to treat  
13 the sick in accord with his needs; freedom to bring the  
14 patient "the very best of medical care" rather than  
15 having to follow preconceived notions of legislators, or  
16 bureaucrats administering legislation in which (as indi-  
17 cated in one of the earlier proposals for an Act for  
18 "Health Insurance" in Canada by the late J.J. Haggerty):  
19 "No interim order or direction of a commission shall be  
20 questioned or reviewed in any court, and no order shall  
21 be made or process entered, or proceedings taken, in any  
22 court, whether by way of injunction, declaratory judgment,  
23 certiorari, mandamus, prohibition, quo warranto, or  
24 otherwise, to question, review, prohibit or restrain a  
25 commission or any of its proceedings". This is an  
26 indication of the sacrifice of freedoms which the  
27 planners of Government-controlled concepts and Acts are  
28 prepared to make in order to assure that everyone accepts  
29 what the planners consider best. It is a form of inter-  
30 ference with our freedom and prohibition of access to  
our courts of justice which is becoming all too common  
and accepted with a degree of complacency which does not  
augur well for the future of freedom. This is the







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attitude to which everyone in general should be alerted, and prepared to oppose. It is, however, more particularly important to guard against it in the field of medical economics and the provision of medical and health care.

s) Finally, our experience and studies lead us to the conclusion that Canada has been and is being well served in the matter of the "existing facilities and methods for providing health services, including prevention, diagnosis, treatment and rehabilitation". Admittedly, there is room for improvement in all the various aspects of the problem. It is indicative of virile progress that deficiencies are recognized. It has, however, been and will continue to be the process of steady evolutionary progress which will bring about the required improvements as they arise. Experience convinces us that the best method, and indeed the only method, of attaining our desired goal is to encourage continuation of evolution which has been progressing in our peculiar Canadian way of democracy.

#### RECOMMENDATIONS

We recommend to this Royal Commission:-

1) THAT they give due consideration and weight to the progress which has been actually demonstrated by the medical profession in Canada in the field of research, therapeutics and medical economics.

2) THAT the Commission give due consideration to the fact that those





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laying claim to having a rapid solution to curing the economic and other ills of the community are those with a very superficial knowledge of illness, its causes and treatment, and in actual practice with patients. Further, that most such advocates have not demonstrated their ability to maintain solvency in any field of private enterprise.

3) THAT the expenditure of large sums of money not be made on grandiose plans based on theories.

4) THAT a permanent Commission be appointed as an independent arm of "The Research Council of Canada" for the purpose of advancing studies and activities in "prepayment for the cost of medical care" already under way and well advanced across Canada.

5) THAT the personnel under such a commission be limited to those who are actively engaged in operating solvent, non-profit and self-sustaining plans for "prepayment for the cost of medical care".

6) THAT the Government of Canada provide funds of not less than one million dollars (\$1,000,000) per annum for a period not exceeding five (5)







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years on the understanding that the licensing bodies of the medical profession in each of the provinces shall be charged with and will accept the responsibility of developing a self-sustaining prepaid medical care program for the self-sustaining portion of the population; and that the provincial governments contribute a rateable portion of the cost for the less fortunate members of the community (e.g. as is done in "The Medical Welfare Plan" in Ontario).

7) THAT the various provincial licensing bodies be urged to consult with their respective provincial Legislatures and the Canadian Association of Medical Colleges with a view to exploring ways and means of giving the medical undergraduate the same course of study in less years than are now required.

8) THAT due consideration be given to, and provision made for the cost of establishing an adequate additional number of medical colleges, or alternate suitable provisions, to assure sufficient facilities, research and training so that the high standard of medical care enjoyed by the population of Canada can be maintained, and our present





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position among leaders in this  
field be assured. The need for  
these facilities is immediate  
and urgent.

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4 THE CHAIRMAN: Thank you very much,  
5 Dr. Hannah. I think I would be derelict if I did not  
6 say to you that the factual information contained in  
7 this submission is bound to be of value to us and to  
8 our research staff, particularly the statistical informa-  
9 tion provided and the historical and other developments  
recorded in the statement.

10 Now, If you wish to make some addi-  
11 tional remarks to your opening general statement, any  
12 observations, perhaps now you might wish to express them  
13 on the impression you appear to have gathered. We would  
14 be very glad to hear it or from those associated with  
you.

15 DR. HANNAH: I do not think I have  
16 anything further to add other than I have already said,  
17 or has been contained in the brief. I do not know whether  
18 my confreres have anything they would like to add to the  
19 statement.

20 DR. WIGLE: I do not think so, we are  
21 looking forward to some questions.

22 DR. PALMER: I have nothing to add.

23 THE CHAIRMAN: Now, Dr. Hannah, perhaps  
24 this may be asking a question on a rather narrower basis than  
25 what you have said, but on Page 2 of your conclusions, the  
26 last sentence in Section B where you are discussing the  
evils of too much money and you say:

27 "Too much money is interfering with the  
28 proper and efficient use of hospital  
accommodation."

29 That is the statement that I would  
30 like to hear you expand, if you will.

.NOY



Hannah 9191

DR. HANNAH: Well, in explanation of that statement I would refer you to the page following, in the middle of Paragraph 31 which contains a pamphlet published by the Ontario Hospitals Commission. Before the Ontario Hospitals Commission came into being, Associated Medical Services in the original instance provided hospital care as well as medical care and although some rise in the utilization of hospital beds is to be expected and is a good thing, one hardly expects it to increase to almost double within a short period of time after the introduction of such a plan.

THE CHAIRMAN: Do you say that is a fact that the utilization of hospital beds in Ontario did double within the year? You have only been operating two years.

DR. HANNAH: I am speaking of our own plan, over a period of time the number of days stay gradually rose from something less than one prior to our taking it on to 1.3 some days. I am quoting these figures without having them before me.

THE CHAIRMAN: Are those absolute or per capita?

DR. HANNAH: This was per capita throughout the Province.

THE CHAIRMAN: If I may understand you, in 1940 there was a utilization of 1,000 gross; what was the utilization in the next period, 1950?

DR. HANNAH: 1,300, there was an increase.

THE CHAIRMAN: What was the increase in population at the same time?







Hannah 9192

DR. HANNAH: I am talking about per individual.

THE CHAIRMAN: All right, if I understand you. And you think that is due, that hospitalization was being made available through your organization and others?

DR. HANNAH: Yes, I do.

THE CHAIRMAN: And merely because the service was being prepaid?

DR. HANNAH: Pretty well, sir.

THE CHAIRMAN: Would you eliminate from that the other arm of that argument that there was no utilization before prepayment, because people were not able to pay and able to afford to go to hospital?

DR. HANNAH: I think that is what I meant to cover when I said one would expect some increase in the utilization but not that much.

COMMISSIONER VAN WART: Did not the change of type of living such as apartment living have a tendency to increase hospitalization?

DR. HANNAH: Well, I will give you an example of what I mean.

THE CHAIRMAN: If you will, because we are trying to follow this. Very many things have been told to us, there is an increasing number of older people in each ten year period and the advancing age group is more inclined to illness and, therefore, perhaps more inclined to hospitalization.

DR. HANNAH: The example I would like to give you is that of a young lady who broke her right



THE UNITED STATES OF AMERICA

Washington, D.C.

STATE DEPARTMENT  
BUREAU OF INVESTIGATION  
WASHINGTON, D.C.

MEMORANDUM FOR THE DIRECTOR

SUBJECT: [Illegible]

REFERENCE: [Illegible]

DATE: [Illegible]

FROM: [Illegible]

TO: [Illegible]

RE: [Illegible]

[Illegible]

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Hannah 9193

wrist and we received an account for 21 days hospitalization. On making inquiry as to why a broken wrist, which ordinarily is set and the patient is home in a few hours, we asked why the 21 days stay. The answer to this came back, "well, of course, the young lady could not do her housework". Now, if she had been paying for her own hospitalization she would have found ways and means of doing her own housework. She was living in an apartment.

THE CHAIRMAN: Are you suggesting in Ontario today such a young lady would be in hospital for 21 days?

DR. HANNAH: I just said that was an actual experience of ours.

THE CHAIRMAN: What year?

DR. HANNAH: Approximately 1945.

COMMISSIONER FIRESTONE: If I may raise two or three questions addressed to Dr. Hannah and his associates. My first question relates to your conclusion F on Page III where you say in this Paragraph that prepayment for the cost of medical care is a unique development in solving the problem of medical economics. You point out it has helped a lot of people in the Province of Ontario and the rest of Canada and you emphasize the fact that this was done without cost to Government. This is correct, sir, but would you not say that prepayment arrangements as they have developed in Canada have helped those that can pay and they have not helped those that cannot pay for medical care services either in full or in part?

DR. HANNAH: I would say that is partly







Hannah 9194

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4 true but not altogether. We, when we started in 1937,  
5 received a great many subscribers who were in this border-  
6 line income group who under ordinary circumstances would  
7 not have been able to pay hospitalization, but because  
8 they were able to budget against it through our organiza-  
9 tion at that time, did come in and were independent and  
10 made it by virtue of the fact that they could pay us  
11 \$2.00 a month and have the cost of their hospital and  
12 medical care taken care of. I will give you an example,  
13 a young boy came to us about 1938 as an office boy and  
14 paid us his regular subscription of \$2.00 a month. Now,  
15 he had no cause for any expenses as far as we were con-  
16 cerned for a period of some three or four years and over  
17 the years he rose to be chief clerk. This boy got  
18 married and they raised their family and he indicated  
19 that it was entirely by virtue of the fact he was able  
20 to budget through our plan that he was able to be self-  
21 sustaining in that particular area.  
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Hannah

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4 I am not one of those who believe that  
5 because there are some people who cannot pay their way  
6 our whole economy should be adjusted to that situation  
7 to the exclusion of the interest of the other people.  
8 I think they should have the opportunity of budgeting  
9 against the cost of care; and as has been done in the  
10 case of the mother's allowance and other unemployed,  
11 the government has taken of those through the plan  
12 operated in conjunction with the Ontario Medical  
13 Association, the Ontario Welfare plan.

14 COMMISSIONER FIRESTONE: Dr. Hannah,  
15 we have been talking about two groups, those that can  
16 make provision of their own because they can pay under  
17 the various prepayment plans, and the welfare cases who  
18 are covered under plans you have mentioned. We have  
19 received a number of criticisms about the adequacy of  
20 these plans, but this is not part of this question. My  
21 question is: What arrangements can be made for the  
22 groups that are in between, the people that are not  
23 welfare cases and therefore not covered under these  
24 government plans you refer to, and people that are not  
25 in the category of income recipients that can afford  
26 to pay these premiums, a group that is generally  
27 described as medically indigent. They could be elderly  
28 people, they could be people who can look after them-  
29 selves and then become unemployed. What happens to these  
30 people? Can you visualize a scheme without turning  
to the government for help?

DR. HANNAH: The group about which you  
are speaking undoubtedly exists, and they will exist  
no matter what field you go into. We have all peculiar







Hannah

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3 problems, financial. And, by the way, I do not like  
4 discussing this problem of medical care on a purely  
5 financial basis, because tied in with it is the other  
6 factor of relationship between a doctor and his patient,  
7 and that has been the tenor of my brief as well. But  
8 this group of which we are speaking, they do exist, but  
9 they do not by any means represent the majority of our  
10 population, nor even do they represent a very severe  
11 percentage of the group of people we have to deal with.  
12 You may say how do I know this. Simply because I came  
13 up from that group and I know it not only from my own  
14 experience in handling this but from practical experience  
15 having been through it. And these people, just the  
16 same as all the rest of us, have weddings, have funerals,  
17 have Christmastime, and they spend anything up to  
18 \$50.00 extra for those things, but they don't try to  
19 ensure themselves. These are things they handle  
20 themselves. I don't think we have to model our whole  
21 economy on the fact that we have a small percentage of  
22 people in this area, nor do I think we should allow  
23 these people to go without care at all. But it has been  
24 done and for years it has been done by the profession,  
25 by other arrangement, and has been done, I think, at  
26 a less costly rate than it can be done by a situation,  
27 if I understand you correctly, in which the government  
28 makes everybody belong to a compulsory health insurance  
29 scheme.

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COMMISSIONER FIRESTONE: You understood  
my question incorrectly, I am sorry, Dr. Hannah. My  
question did not deal with everybody becoming a member





Hannah

9197

covered by a compulsory plan. My question was how do you provide coverage for the group which we have described as the medically indigent? Is that question clear and simple?

DR. HANNAH: It is, and I think I have given you as simple an answer as I can, because the answer isn't simple.

THE CHAIRMAN: Dr. Hannah, you tied the tail to it of a compulsory, all-inclusive plan. Now, I ask myself what is the dominant reason in Dr. Hannah's answer? Is it because he is against all plans because some may be compulsory?

DR. HANNAH: Perhaps Dr. Wigle would like to answer that.

DR. WIGLE: I think Dr. Hannah believes that any plan that is going to give prepaid medical care to the people has to have the co-operation of the medical profession, and the medical profession in Ontario have already signified ---

THE CHAIRMAN: Now, let's stay on the ball. The question, and Dr. Firestone's question, is: If we acknowledge that there is a low income group just above the social aid level but below the level of those who are able to pay for premiums -- that is the group you are talking about?

COMMISSIONER FIRESTONE: Exactly, medically-indigent.

DR. HANNAH: This, I suggest, sir, belongs in the category of a welfare medical plan.

THE CHAIRMAN: You would put them all in







Hannah

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3 the same plan?

4 of the practice of DR. HANNAH: Yes.

5 COMMISSIONER FIRESTONE: You are saying  
6 that government assistance should be required to these  
7 people and the medically indigent who at the present  
8 time are not in the category. In other words, you would  
9 like to see government assistance extended to the  
10 second group?

11 DR. HANNAH: I would not like them to  
12 be left out without medical care. We have provided it  
13 in the past, and I think it can be provided in the future  
14 as well.

15 COMMISSIONER FIRESTONE: There is a  
16 bit of difference between the past and the future,  
17 because if I understand you correctly, you say that some  
18 people in this category in the past had been receiving  
19 medical attention by the courtesy and charity of the  
20 doctor because he felt it was his Christian duty and  
21 professional duty to do so. Now, the people we are  
22 talking about in the future, these people would be  
23 covered and would not have to rely on the good nature  
24 and the charity of the doctor but their premium would  
25 be paid for by a government. There is a bit of  
26 difference between the system in the past and the system  
27 in the future. You would be agreeable to having the  
28 government pay the premiums of the medically-indigent  
29 group. Am I correct?

30 DR. HANNAH: If you are going to  
leave some degree of responsibility with -- the medical  
profession, as you say, has done this throughout the years,





Hannah

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4 and I think it is part and parcel of the satisfaction  
5 of the practice of medicine that they have done it and  
6 are doing it and are prepared to do it in the future  
7 if necessary. But if we are going to govern ourselves  
8 by that group, then I would prefer to see that group  
9 handled as they have been in the past. This is my own  
10 opinion.

11 COMMISSIONER FIRESTONE: I am sorry,  
12 I do not quite understand your last remark. Are you  
13 still of the view that, as I understood what you  
14 expressed earlier -- and please correct me if I don't  
15 understand you correctly -- that this group called the  
16 medically-indigent group be treated the same way as  
17 the indigent group?

18 DR. HANNAH: I say they could be, yes.

19 COMMISSIONER FIRESTONE: Would you,  
20 speaking for your association, be in favour of such a  
21 provision?

22 DR. HANNAH: It depends what the  
23 conditions are under which that is made possible.

24 COMMISSIONER FIRESTONE: Well, if the  
25 conditions are in line with recommendations which the  
26 Ontario Medical Association has made to the Provincial  
27 Government, which we were made aware of the other day,  
28 and along the lines proposed by them, would you endorse  
29 this proposal?

30 DR. HANNAH: I would have to see the  
plan, sir. I cannot speak on a hypothetical plan.

THE CHAIRMAN: Doctor, you are the  
president of the Royal College of Physicians and Surgeons.







Hannah

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3 DR. HANNAH: No, sir, I am president  
4 of the College of Physicians and Surgeons.

5 THE CHAIRMAN: Are you not familiar  
6 with the Ontario Medical Association's views of which  
7 you are a member?

8 DR. HANNAH: I am familiar, sir. I  
9 repeat that before I could give my opinion on that as  
10 to whether it did or did not fit in with these conditions  
11 I would have to see the plan. I am in agreement with  
12 the broad principles laid down by the medical profession  
13 in these respects, but there is quite a difference  
14 between talking about broad general principles at any  
15 one time and the actual setting up of any particular  
16 plan under which these things are to be done. I would  
17 not care to express an opinion about it until I had  
seen what it included in the terms of such a plan.

18 COMMISSIONER FIRESTONE: But you are  
19 endorsing, if I understand correctly, sir, the principle  
20 that government assistance should be made available to  
21 pay for the premium of this group. Am I correct in  
that understanding?

22 DR. HANNAH: I said it is one way  
23 in which it can be done, and I agree it is one way in  
24 which it can be done.

25 THE CHAIRMAN: The other way is to  
26 continue on the charity of the medical profession?

27 DR. HANNAH: Under certain circumstances  
28 I would prefer to see it done that way.

29 THE CHAIRMAN: The other alternative  
30 is more unpleasant, just do without medical service?





Hannah

9201

DR. HANNAH: No, there is another way it can be done and which I believe might be reasonable.

THE CHAIRMAN: That is what we want to hear from you.

DR. HANNAH: Given time, it would be possible to apply the principles that have been applied by the medical profession. It would be possible to develop in private, non-profit organizations, a system whereby the cost of these people would be included with the well people by adding a few cents here and there. By the way, I do not agree that there are nearly as many of these people in the aged group as has been suggested by people here today, and I do not believe that there are a great many people over the age of 65 who are indigent and I do not believe there are a great many people over the age of 65 who require more attention than the average run of the mill people. That is not in accord with our association.

COMMISSIONER FIRESTONE: Maybe a lot of indigent people do not come to your association, may not come to your attention.

THE CHAIRMAN: The doctor was talking about over-age.

COMMISSIONER FIRESTONE: Yes, over-age.

DR. HANNAH: They probably wouldn't, but I live in the community the same as you, sir, and I have an opportunity of seeing these people, and that is my experience. Not only from that point of view but from the point of view that we have carried these people on. We started in 1937, a certain number of people came







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TORONTO, ONTARIO

Hannah

9202

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4 to us, and we still had some 37,000 people on that plan.  
5 At first we made certain exclusions of these people.  
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Hannah 9203

Then we passed the regulation that after five years we could remove the exclusion of these people. After another four or five years we decided we would carry --- in the original instance we carried as long after 65 as before. Then we began removing this exclusion and we haven't cancelled anybody because of the over age factor for some ten or twelve years now. The interesting thing is the reserves in the plan have gone up faster than the reserves in our other plans.

COMMISSIONER FIRESTONE: Dr. Hannah, thank you very much for your explanation. May I now turn to recommendation 6 on Page II. You say and I quote: "That the Provincial Governments contribute a ratable portion of the cost for the less fortunate members of the community". Can you explain to us what you mean by "ratable portion"?

DR. HANNAH: There may be a certain number of these people who can --- we have been talking about the marginal group and you will note I suggested that could be taken care of by the Medical Welfare Plan in Ontario. I would suggest that they should pay the portion of the cost of their care of which they are capable.

COMMISSIONER FIRESTONE: So what you had in mind in this recommendation 6, sir, is to take care of the needs of the medical indigent and then have them pay whatever share they can afford to pay and let them pay that part themselves and have the balance made up by the Provincial Government. Is that the meaning of this sentence?







Hannah 9204

DR. HANNAH: That is one way in which it could be done, yes.

COMMISSIONER FIRESTONE: I appreciate it is one way. Is this part of your recommendation in Paragraph 6 on Page II?

DR. HANNAH: Is that what?

COMMISSIONER FIRESTONE: Part of your recommendation.

DR. HANNAH: Yes.

COMMISSIONER FIRESTONE: Thank you. If I may turn to Paragraph 13 on Page 6 of the actual brief you explain in this Paragraph what you call the most primary consideration in the application of the insurance principle to medical care and I quote: "The incidence of risk must be spread over a large number of people representing a normal cross-section of the population and the risk must be spread over a long period of time". Now, Dr. Hannah, how many persons does your Association cover?

DR. HANNAH: Does our organization?

COMMISSIONER FIRESTONE: Your organization.

DR. HANNAH: 259,000, roughly.

COMMISSIONER FIRESTONE: Now, would you say that 259,000 is a large number of people representing a normal cross-section of the population?

DR. HANNAH: It depends on where the people are taken from. If they are taken from the average mill-run of the population, yes, they would represent a large group, cross-section of the community. On the other hand, if you take them from industry or one large





Hannah 9205

group that would be different, but they do represent, insofar as we are concerned, a cross-section of the community pretty well.

COMMISSIONER FIRESTONE: I am not referring to a hypothetical case, Dr. Hannah, I am referring to your actual experience. Would you say that persons covered by your Association are in the wording of Paragraph 13 a large number of people representing a normal cross-section of the population? I am referring to your actual experience, sir.

DR. HANNAH: I think I have answered that. I think I said the 259,000 people we have does represent a cross-section of the community.

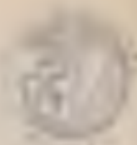
COMMISSIONER FIRESTONE: Now, if you could extend this cross-section of the community which you now have to the extent of 259,000 to say, a million, would you feel that you could offer better terms to those covered or would you feel that this wouldn't achieve any further advantage so far as the insured membership is concerned?

DR. HANNAH: I doubt if it would.

COMMISSIONER FIRESTONE: Thank you very much, sir.

THE CHAIRMAN: Just one thing: You may be able to give me some help here, Doctor, on Page 80, on the last page of the brief you give a break-down of those enrolled in a doctor approved plan. I notice you do not include the 272,000 we heard about this afternoon in the Medical Co-op, nor the 240-some-odd thousand in Les Services de Santé in Quebec, and then we know there





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From that we have the following, but they are not

the same as the following, a description of the

which is not well.

With this I am not

referring to a hypothetical case, on which, I am

referred to your own experience. With you a very

careful observer, in the course of the year or of

some, especially of the population, I am not

at all. I think I have not

the same, but I am not

representative of the whole

with this, I am not

and now we have the same, but I am not

would you not feel that you are not

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Hannah 9206

are other medical co-ops, certainly one in Saskatchewan an "X" number of members. What I am wondering is why these are not counted in what might be called approved plans.

DR. HANNAH: The table as shown there, sir, is just what it says: Dates of Establishment and Enrolment of Doctor-Approved Plans in Canada. I didn't think under that heading to include some of them that weren't in that particular group. I recognize that they are there and recognize the valuable job which these people are doing. I was dealing in this particular situation, and I was dealing with the history and development of doctor-sponsored prepaid medical care plans in Canada, therefore, I didn't think to include those others in it.

THE CHAIRMAN: Do you put a higher value on doctor-sponsored than on patient-sponsored plans? Do you put one or the other in a higher category or a lower category than the other?

DR. HANNAH: No, sir, I don't put one in a higher category or a lower category, but I believe there are certain elements in the one that will lend to stability and longevity that are not present in the other. This is a point over which, I am sure, protracted argument might take place.

THE CHAIRMAN: I am not going to argue the point with you, because I am not familiar with the situation.

DR. HANNAH: One of the elements, sir, in this latter part of my brief is that prepayment for the cost of medical care as we have seen it here was





Hannah 9207

started with the medical profession in a small way.

THE CHAIRMAN: Would you accept, Doctor, that the medical co-op in Saskatchewan pre-dated the medical doctor-sponsored program?

DR. HANNAH: That is true, probably, in Saskatchewan.

THE CHAIRMAN: Will you accept it is also true it is almost day for day with the establishment of the Windsor Plan which was said to us today to have been the earliest in Ontario?

DR. HANNAH: Sir, I don't wish to get at cross purposes here. I am quite prepared to accept these plans, whenever they started, have done an excellent job. What I am trying to say is that over this period of time since 1937 -- there was a small group --, we enrolled one person or ten people on the 1st of June, 1937 when we opened our office and from that has grown this organization not only of A.M.S., but of the Trans-Canada Medical Plans as you have seen them represented here today, and along with that has grown the Co-ops and there has been an entry of commercial companies into a much broader field of coverage than ever extended prior to the institution of this plan, or the beginning of these plans.

COMMISSIONER BALTZAN: I might say this element of development, speaking back of the "dirty 30's" there has been spontaneous direction and simultaneous development of the idea of pooling the resources, and even at that stage the word prepaid medical services wasn't as common as it is now. There was then in progress







Hannah

9208

the idea of pooling the resources in order to have security in time of sickness, and simultaneous with the medical profession and in two instances in Saskatchewan ahead of the medical profession lay groups commenced to organize. Is that what you refer to?

THE CHAIRMAN: Yes.

DR. HANNAH: I would say further in Texas there was a pooling of resources insofar as hospital plans before that. What I am trying to convey here is that with the start of this there has been this blossoming out, and I personally visited twelve States of the Union to help them organize their plans. I think I took part in the organization of most of the plans across Canada in one way or another. My point is this has been a gradually increasing growth, and in my opinion, if that growth is allowed to continue then we will have a much more satisfactory answer to the problem than if we try to foresee all the problems all at once, and solve them, because I can speak from experience that repeatedly the things we expected to encounter as difficulties in our operations in the theoretical stage proved not at all to be difficult, and the things we did not expect were the ones which tripped us up.

THE CHAIRMAN: Are you satisfied with your rate of progress, with what the graph shows?

DR. HANNAH: I think it is a very nice growth, sir, and I believe it will grow faster in the next few years.

THE CHAIRMAN: Since the War, I take it, since about 1950.

DR. HANNAH: Approximately since 1950, sir.





Hannah

9209

COMMISSIONER STRACHAN: Mr. Chairman,  
I wonder if Dr. Hannah would like to comment on the last  
sentence of conclusion B of II: "Too much money is  
interfering with the proper and efficient use of hospital  
accommodation at the present time".

THE CHAIRMAN: I put that question to  
the Doctor at the beginning.

COMMISSIONER STRACHAN: I realize that,  
and I wonder if he would care to comment further on that.

DR. HANNAH: I don't know, Mr. Chairman,  
that I have much more to say on the proposition. It  
appears to be a concept of the Commission itself in that  
they published this pamphlet I have put in here as an  
exhibit.

THE CHAIRMAN: It is an interesting  
pamphlet.

DR. HANNAH: Pardon?

THE CHAIRMAN: It is an interesting  
pamphlet.

DR. HANNAH: Yes.

THE CHAIRMAN: You may have recognized  
on the program we are going to bring before us a number of  
hospitals and organizations to discuss this very question  
of the history of utilization or over-utilization, as the  
case may be. We will pursue it with those who actually  
give that service. We hope we may get some assistance  
from the hospital administrators in that regard.

COMMISSIONER BALTZAN: Mr. Chairman,  
I would like to make this one mention, that you have, sir,  
performed a very splendid service in your review of the





TO THE HONORABLE MEMBERS OF THE HOUSE OF REPRESENTATIVES

I was so glad to hear that you were so much interested in the first

session of the Commission on the part of the House.

It is very interesting to see a member of the House so interested in the

work of the Commission.

THE CHAIRMAN: I put that question to

the House at the beginning.

and I wonder if we could come to a decision further on that.

THE CHAIRMAN: I don't know, Mr. Chairman.

that I have been asked to say on the proposition. It

seems to me that the Commission itself in the

they will have to say that I have not done as an

It seems to me it is an interesting

and I think it is an interesting

It seems to me it is an interesting

It seems to me it is an interesting

THE CHAIRMAN: You may have had some

on the subject of the House of Representatives as a number of

members of the House of Representatives have raised this very question

of the House of Representatives as a number of

members of the House of Representatives have raised this very question

of the House of Representatives as a number of

members of the House of Representatives have raised this very question

I wonder if you would like to see the report of the Commission, Mr. Chairman.

It seems to me it is an interesting



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# ROYAL COMMISSION ON

Hannah

9210

essence of the field of medical service with your historical review. It is very timely. A lot seems to be going in the other direction.

DR. HANNAH: There is one thing I intended to say when I started out. I come from Saskatchewan.

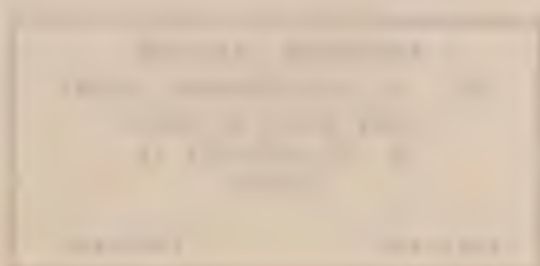
THE CHAIRMAN: We still have some Hannahs there.

DR. HANNAH: Yes, sir.

THE CHAIRMAN: Thank you very much, Dr. Hannah. I join with Dr. Baltzan in what he said.

We will adjourn to tomorrow morning at nine-thirty A.M.

---Whereupon the hearing adjourned.





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# ROYAL COMMISSION ON HEALTH SERVICES

HEARINGS

HELD AT

TORONTO

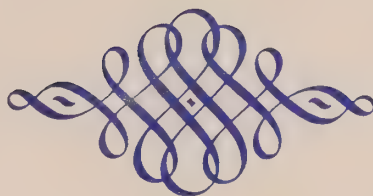
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TORONTO, ONTARIO

ROYAL COMMISSION ON HEALTH SERVICES

Proceedings of the hearings  
held in Toronto, Ontario,  
on the 9th day of May, 1962.

COMMISSION MEMBERS:

Chief Justice EMMETT M. HALL -- Chairman

MISS ALICE GIRARD, R.N.

DR. C. L. STRACHAN

DR. ARTHUR F. VAN WART

MR. M. WALLACE McCUTCHEON, Q.C.

PROF. O.J. FIRESTONE

DR. DAVID M. BALTZAN

COMMISSION COUNSEL:

MR. R. N. HALL, Q.C.

MEDICAL COUNSEL:

DR. PIERRE JOBIN

DIRECTOR OF RESEARCH:

PROF. BERNARD BLISHEN

COMMISSION SECRETARY:

MR. N. LAFRANCE







---On resuming at 9:30 a.m.

DR. JOBIN: Mr. Chairman, the first submission this morning will be presented by the Registered Nurses Association of Ontario. This brief will be known as Exhibit 247. There is a supplement to the brief that has just been distributed which will be known as Exhibit number 247A.

---EXHIBIT NO. 247: Submission by the Registered Nurses Association of Ontario.

---EXHIBIT NO. 247A: Supplementary submission by the Registered Nurses Association of Ontario.

DR. JOBIN: The presentation will be made by Mrs. Duncanson. Mrs. Duncanson will you present your group?

SUBMISSION OF  
THE REGISTERED NURSES ASSOCIATION OF ONTARIO

APPEARANCES:

Mrs. M. Blanche Duncanson  
Miss Ella M. Howard  
Miss Laura W. Barr  
Miss Gladys J. Sharpe  
Dr. Kenneth G. Gray, Q.C.  
Miss Marjorie G. Russell

MRS. DUNCANSON: Mr. Chairman, and Commissioners, may I first introduce the members of our Association and our legal counsel who are representing the Association this morning. To my right is Miss Laura



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4 Barr, our Executive Secretary, and Miss Gladys Sharpe,  
5 a member of the Registered Nurses Association of  
6 Ontario and the senior consultant on nursing with the  
7 Ontario Hospital Services Commission. To my left is  
8 Dr. Gray, our legal counsellor. Miss Marjorie Russell,  
9 a member of the Registered Nurses Association of Ontario  
10 and presently engaged in the office at our Association.  
11 Miss Ella Howard, past president of the Registered Nurses  
12 Association of Ontario and presently Director of Nursing  
at the New Mount Sinai Hospital.

13 THE CHAIRMAN: Now Mrs. Duncanson if  
14 you were prefer to sit, it would be very acceptable.

15 MRS. DUNCANSON: Thank you sir. This  
16 brief of the Registered Nurses Association of Ontario  
17 has been prepared by a committee of Association members  
18 representing administration in nursing services and  
19 education in university and hospital schools, and has  
20 been approved by the Executive Committee.

21 In its preparation we reviewed the  
22 beliefs which the Association has held in relation to  
23 the provision of nursing service and education and  
24 attempted to identify the future contribution which  
25 nurses will need to make in health care as envisaged  
26 in the terms of reference of the Commission's enquiry.  
27 The recommendations contained in the brief reflect  
28 measures which we believe to be necessary to the  
29 attainment of this goal.

30 The Association welcomes the opportunity  
to present its brief to the Royal Commission on Health  
Services.







SUMMARY:

1. The Association concurs in the belief that health services of the highest quality should be available to all Canadians according to their need and is hopeful that nurses may fulfil their part in providing these services.

2. We accept the assumption that the role of nurses will continue to evolve with scientific and social change and believe that nursing must participate to a greater extent in health planning and the development and co-ordination of nursing services within these plans.

3. We believe it to be in the public interest to license all who practise nursing for a fee or other remuneration.

4. We propose that nursing care should be given by two categories of nurses, one of which is a graduate of a university school and the other a graduate of a diploma school which is conducted within the framework of general education with the hospital and other health agencies continuing to provide clinical facilities for the students of both programs. Until a suitable diploma program may be established the present hospital schools of nursing and training programs for nursing assistants must continue, but improvement in the hospital schools is possible if control of the school is separated from that of the hospital.

5. We consider that it will be necessary to increase the number of university graduates and that







educational programs should be further developed to meet the need of graduate nurses for advanced study. Increased bursary assistance will be required for all programs of nursing education if a sufficient number of nurses is to be available.

6. We are concerned about the many reported shortages of nurses and believe that measures can be taken to narrow the gap between the demand for and the supply of nursing services. These measures include increased recruitment of students, improved education and equitable returns for service. Another source of available nursing service may be had through the transfer of many housekeeping, clerical, dietary and other duties from nursing to their appropriate departments.

7. Good administrative practices and skilled nursing are encouraged through additional study and experience and inservice educational programs. It will be necessary to increase research in nursing, particularly in relation to nursing care. In the interest of maintaining a high quality of nursing in an expanding health program, this is an urgent need.

8. We are concerned with the welfare of our members. We are also concerned with the provision of a sufficient supply of nurses and a high quality of nursing care. To meet these requirements we believe that changes in policies including salaries are necessary.

#### RECOMMENDATIONS:

1. That complete health care be made available to all Canadians regardless of their financial







condition.

2. That provision be made to require licensing for all who practise nursing for a fee or other remuneration.

3. That the nursing profession be given statutory responsibility for the development and implementation of regulations governing the education and practice of nursing.

We submit that the intent of recommendation 3 has been achieved in part in Ontario by recent action of the legislature. A bill to establish a College of Nurses received final reading and assent on April 17, 1962. A new Act, "The Nurses Act 1961-62" is based on the principle that a profession determines its standards of education and practice. It provides for establishment of a statutory body, a College of Nurses, whose affairs will be administered by a council elected by and representing every member of the profession resident in Ontario. This Act now awaits proclamation. A copy of the Act, sir, has been attached to the supplemental statement.

In the Association's brief, reference has been made to the Nurses Registration Act which has been administered by the Association since 1951. This Act and accompanying regulations will no longer be in effect with the proclamation of the new Nurses Act.

4. That the preparation of the professional nurse be the responsibility of the universities.  
5. (a) That the preparation of the nurse in a diploma program be conducted within a general



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4 system of education.

5 (b) That study be undertaken to  
6 determine the most suitable way this may be accomplished.

7 6. That additional courses, leading to  
8 the Master's and Doctor's degree be established in  
9 Ontario.

10 7. That bursaries be made available in  
11 sufficient amounts to remove financial impediment for  
12 suitable candidates in:

13 (a) basic nursing courses

14 (b) postgraduate studies in university.

15 8. That in the process of planning for  
16 health care there be representation from the public  
17 and from the medical, nursing and other professions  
18 contributing to health.

19 9. That a study of the utilization of  
20 nurses be undertaken by the Royal Commission on Health  
21 Services.

22 10. (a) That pending a study of utiliza-  
23 tion of nurses, health agencies review present policies  
24 with a view to improving utilization locally.

25 (b) That specialization in clinical  
26 nursing be encouraged at the graduate level.

27 (c) That inservice educational  
28 programs be a requisite for all staff in health agencies.

29 11. That training programs and financial  
30 resources be made available for research.

12. That the salary of the nurse reflect,  
more equitably, her preparation and the responsibility  
she is expected to assume.





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Duncanson

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3 13. That the salary for general practitioners  
4 in nursing be expanded to provide sufficient remunera-  
5 tion for nurese with specialist qualifications in the  
6 area of direct care to patients.

7 This concludes the recommendations  
8 that our Association would place before this Royal  
9 Commission. We, as a representation, would be pleased  
10 to attempt to answer questions that you, Mr. Chairman,  
11 or members of your Commission would wish to ask our  
12 Association.

13 THE CHAIRMAN: Thank you very much  
14 Mrs. Duncanson. I would ask Miss Girard if she will  
15 open the discussion.

16 COMMISSIONER GIRARD: Mr. Chairman,  
17 Mrs. Duncanson, if I ask you the questions, I wish you  
18 would feel free to pass them on to any of your  
19 colleagues if you feel that some of them should be  
20 answered by any one of them.

21 MRS. DUNCANSON: Thank you.

22 COMMISSIONER GIRARD: I will take the  
23 brief and recommendations in line, skipping the first  
24 one thinking that it might come back a little later  
25 on, but on page 4, right after the first recommendation  
26 you say "care for the mentally ill should be more  
27 readily available in home communities ...", et cetera.  
28 Are you thinking here about nursing of the mentally ill?  
29 You say they should be more available in communities.

30 We have been hearing a lot of having  
mentally ill patients taken care of in, or right near  
the general hospital. Are you referring to this or are





Duncanson

9218

1  
2  
3  
4 you referring to the nursing part of the care of the  
5 mentally ill?

6 MRS. DUNCANSON: Mr. Chairman, I  
7 would submit that in this statement we were primarily  
8 concerned with the nursing care but we were expressing  
9 an opinion as to where this care might take place.

10 COMMISSIONER GIRARD: I just wanted  
11 to bring this back to nursing because it has been brought  
12 out in one of the hearings that there are only two  
13 provinces, two provincial nursing associations that  
14 make the affiliation in mental, psychiatric hospitals  
15 compulsory for student nurses in the basic course and  
16 I was wondering if you would like to comment on that.

17 -

22 -

28 -





you believe in the value of the word of the  
scripture.

My dear friend,

Wrote a little that is a statement of some religious  
convictions. I am sure that you will find it a most  
interesting and useful book.

I am, my dear friend, your  
affectionate friend,

to bring this to the attention of those who have been

out in one of the papers and those who are two

prominent and prominent and prominent that

take the attention of the public, especially the

community for a long time in the public and

I was wondering if you would like to know or that.



Duncanson

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4 MRS. DUNCANSON: In this province it is  
5 not a compulsory requirement in the basic preparation of  
6 our students. The factors which have militated against  
7 this being accomplished has been the lack of accommodation  
8 but more specifically, the lack of prepared personnel in  
9 the area to provide a suitable program of affiliation  
10 for the student.

11 I believe at the present time about 25%  
12 of our students receive affiliation experience in  
13 psychiatry in Ontario.

14 COMMISSIONER GIRARD: 25%?

15 MRS. DUNCANSON: Yes - I am sorry, it  
16 is 75%.

17 COMMISSIONER GIRARD: I had hoped so.  
18 You see why I am bringing this up. We are very much  
19 concerned now about mental health and about the care  
20 mental health patients are getting. This has been  
21 brought up in every province and in a number of briefs.  
22 If we are going to have more facilities for the care of  
23 the mentally ill we have to have more nurses prepared to  
24 take care of the mentally ill.

25 In the western provinces we heard about  
26 psychiatric nurses. Coming back to our own group, our  
27 own professional group, our own registered nurses group,  
28 I think it is important to think about what we are doing  
29 in order to get these nurses prepared for this task. I  
30 was very much surprised to hear there were only two  
nursing associations that made it compulsory; I thought  
it was almost universal in every province in every associa-  
tion.





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MRS. DUNCANSON: Miss Girard, our Association has gone on record as recommending this but until such time as the facilities were available it was not possible to include in our regulations.

COMMISSIONER GIRARD: Could you see it becoming possible in the near future? Being a progressive Association I am sure you can.

MRS. DUNCANSON: We certainly will work towards it within the intent of experience with students in this particular area.

COMMISSIONER GIRARD: It seems to me a vicious circle; you do not have enough graduate nurses working in psychiatric hospitals to be able to look after the students that would go through. However, even though it is a vicious circle we must get out of it some day.

On page 5, paragraph 10, you have this paragraph that refers to your recommendation on page 6, that the profession be made to require licensing for all who practise nursing for a fee or for remuneration.

Before you came this morning I had a question on this; it seems only reasonable to expect that both responsibilities be placed under one jurisdiction. Talking about the two responsibilities, now, you do have the Act that you circulated just before the Commission started this morning. Would you please comment as to how it will function since I am sure the Commissioners did not have time to look at it?

MRS. DUNCANSON: Mr. Chairman, in the past, nursing affairs in this province have been regulated by two Acts; the Nurses' Registration Act which has been





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from the time we started at the beginning of the year until  
the time we finished it was not  
possible to find in any of the  
files of the FBI. I could not see it  
because it was in the hands of a progressive  
Association and I was not one.  
I am sure that the work  
to be done in the interest of expanding with students  
in this particular area.  
I am sure that it seems to me a  
violation of the law; you do not have to make names  
known in a public hospital, to be able to look after  
the students that would be there. However, even though  
it is a violation of the law we did get out of it some day.  
In regard to paragraph 12, you have this  
reference that refers to your contribution on page 6,  
that the profession be made to receive nothing for all  
who put the money for a fee or for remuneration.  
As one you came this morning, I had a  
feeling on that it seems only reasonable to expect  
that both responsibilities be placed under one jurisdiction.  
Taking apart the very complicated, now, you do have  
the fact that you have not yet heard the Commission  
accepted this morning. And you please consent as to how  
it will function since I am sure one of the officers did  
not have time to look at the  
and, finally, I think it is that you have been registered  
in two ways; the first, I think, is that which has been



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administered by the Registered Nurses' Association of Ontario which was responsible for establishing standards of admission to schools, the educational program within the school, the establishment of registration examinations, the procedures of registration, the renewal of registration, the cancelling, suspension and revocation of certificates of registration.

The Nursing Act has been administered by the Department of Health and this Act had regulations in relation to the approval of schools of nursing and training centres for the certified nursing assistant; the educational requirements within the training centres for certified nursing assistants, certification of this group and the licensing of commercial registries.

In the implementation of these two Acts it meant that one group was prescribing certain educational requirements within the schools themselves in relation to the program and these regulations were being essentially inspected to see that they were carried out by another group. In this new Act there is a consolidation of all these functions into one body. In the initial intent it was hoped that the Act might proceed to include licensing but this has not been achieved. There has been a consolidation of the two previous Acts so that the affairs of nurses and nursing in relation to standards of education, the conduct of the schools and training centres, the discipline of the registered nurses and the certified nursing assistants, will be subject to a College of Nurses whose affairs will be administered by a Council.

This Council will be composed of members







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who will be elected by every nurse resident in Ontario. There will be representation on the Council from the Registered Nurses' Association of Ontario and from the Association of Certified Nursing Assistants in Ontario.

Until such time as the electoral procedures can be achieved and regulations completed, the affairs of the College will be administered by a professional Council composed of five members of the Registered Nurses' Association of Ontario who will be appointed by the Lieutenant-Governor in Council.

COMMISSIONER GIRARD: Mrs. Duncanson, when you say, talking about the College, you say "whose affairs will be administered by a Council elected by every member of the profession residing in Ontario", how will this be carried out?

MRS. DUNCANSON: Miss Girard, we do not have the procedures outlined up to the present time. We felt that this will be subject to the direction of the provisional Council when it is appointed but at the moment we do not have this procedure defined nor the regulations drawn up to provide for this.

COMMISSIONER GIRARD: Well, you now have a provisional Council; what are the functions or - the French word comes to my mind first, les attributions - the rights of the professional Council, until you have this other? Will it determine how this election of the members of the College will be made, this election that is supposed to be made through every nurse?

MRS. DUNCANSON: At the present time we do not have the provisional Council, it still has to come







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into being but as soon as it is appointed it has the responsibility to do everything to bring the Act into operation. Perhaps Dr. Gray would like to answer this.

THE CHAIRMAN: I thought perhaps Dr. Gray might have an observation to make on that.

DR. GRAY: I think Mrs. Duncanson has summed it all up when she said the function of the professional Council which was to be appointed by the Government, consisting of five registered nurses and their functions will be to do everything to establish the machinery to enable the Act to be proclaimed. Its function will be to draft the regulations and that will include the electoral machinery which Miss Girard has asked about.

COMMISSIONER GIRARD: At this time do you know what representative bodies will be on the statutory body?

DR. GRAY: Yes, that is laid down in the Act.

THE CHAIRMAN: Section 3 of the Act.

DR. GRAY: The Minister of Health or his representative, members elected by the registered nurses of Ontario and then, registered nurses appointed by the Association and then representatives of the certified nursing assistants. I think it is the intention that the elected representatives would probably be on a district basis in such a way that there will be representation by population.

MRS. DUNCANSON: That is our intent in our original consideration of this matter.



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COMMISSIONER GIRARD: Will all these people be voting members, these persons on the Board?

MRS. DUNCANSON: On the Council, yes.

DR. GRAY: Oh, yes.

COMMISSIONER GIRARD: Even the representative from the nursing assistants?

MRS. DUNCANSON: Yes.

COMMISSIONER GIRARD: I am sorry if I have been asking all these questions and we have the Act before us but, as you realize, we have not had time to read it. This Act has caused a lot of comment throughout Canada and the nurses are very much interested in it.

I remember being at a hearing when it was announced in the newspapers and we want to know more about it and that is why I am asking these questions.

Could you tell us in one sentence or in a short sentence what is the essential difference that the College will have with the Licensing Act?

MRS. DUNCANSON: At the present time, in our province, we do not have a Licensing Act.

COMMISSIONER GIRARD: For the provinces that have it, what would be the main difference?

MRS. DUNCANSON: This Act, as I understand it, makes provision for the minimum requirements a person must have in their preparation in order that they may be registered as either a nurse or a nursing assistant. Licensing, as I understand it, is a permit to practise nursing but in this province this Act will essentially control the minimum standards and the nomenclature of the person who sets herself out as a registered nurse or







Gray

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a registered nursing assistant.

COMMISSIONER McCUTCHEON: Surely the registration is equivalent to licensing, is it not, Dr. Gray?

DR. GRAY: Yes sir, except in Ontario even after this Act is proclaimed a person may still practise nursing without being registered or without being qualified at all.

COMMISSIONER McCUTCHEON: That is true but may not designate themselves as a registered nurse or a certified nursing assistant.

DR. GRAY: That is right.

COMMISSIONER BALTZAN: Does this seem to correspond to what the medical organizations have in the way of the College of Physicians and Surgeons, this College of Nurses?

DR. GRAY: In a general way, yes. The exact constitution of the governing body is somewhat different but the broad principle is the same that it will be a governing body elected by the profession. I think that is the fundamental principle.

COMMISSIONER GIRARD: On page 5, paragraph 11, you state:

"Nursing is being practised by several categories of so-called nurses. In addition to registered nurses and certified nursing assistants there is a large number of persons with varying degrees of training or experience ---"

And then at the bottom you say the number



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has been estimated at 30,000. Could you give us more information on these 30,000 so-called nurses who are doing nursing? You say nursing is being practised by several categories of so-called nurses; what kind of nurses come into this category, these 30,000?





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MISS DUNCANSON: This group is composed of persons who set themselves up as licensed nurses, who may have obtained what they believe to be a licence through a correspondence school. They may be people who are very practical in nature, in that they are able to provide care of persons when they are ill in their homes. They may be nurses who have been prepared in various programs of varying lengths, but are not eligible for registration in this Province. They may come from other countries, or they may be so-called graduates from schools of nursing who are not eligible for registration within Ontario. We recognize that the preparation of persons who have had first-aid courses is not considered to be a preparation for nurses, but we have evidence that there are persons using this as a qualification to entitle them to nurse.

COMMISSIONER GIRARD: Where would you say that these 30,000 nurses are nursing, mostly in homes, or in?

MISS SHARPE: Miss Girard, I feel that many of these categories have turned up in the reports that have come in from the hospitals in the Province, when there has been an attempt made to sort out the many categories into two groups, and where they don't fall into the group of registered nurses, nor yet in the certified nursing assistants group, then you find them classified as nurse aides, nurse assistants. You hear of well-baby nurses, sick-baby nurses, maternal nurses, and obstetric nurses, who do not come into this classification, and I believe there are many employed in the hospitals in the Province.





Sharpe 9228

COMMISSIONER GIRARD: "More or less in the nursing field, but doing marginal tasks?"

MISS SHARPE: Right.

MRS. DUNCANSON: Mr. Chairman, I am not sure that they are always marginal tasks, and this is why we have recommended that there be provision for all who nurse for like or higher remuneration.

COMMISSIONER GIRARD: On Page 7, Paragraph 14, I think I must congratulate the writers of this brief for giving us a good definition of the role of the nurse prepared in the university, as against the role of the nurse prepared in diploma schools.

We have heard a lot of the two categories, and I don't think we got this definition as clearly before. I think this is a very helpful part of the brief.

At the end of Paragraph 14 you say:

"With additional preparation and experience, she may become an administrator, teacher or clinical specialist in nursing".

I would like to have your help on a little problem here.

It seems to me that when this person gets her degree and goes out in the field, I think the intent is that you would like to see her do some general nursing, before going on to get more experience before going on to some administrative position, such as head nurse, or something. How do you keep the hospitals, they are crying for prepared nurses, to use these nurses immediately in administrative positions, and how long do you feel these nurses should have in a non-administrative position before going on to the role of head nurse or supervisor?

MRS. DUNCANSON: Our Association, I







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believe, has gone on record as indicating that we feel they should have at least one year of experience before proceeding to take post-basic study. Our problem, however, in retaining this person at the bedside of the patient is two-fold. One, our need for well-prepared nurse leaders. These persons do have the preparation to assume positions of greater responsibility, and are urged by employment agencies to assume these positions.

COMMISSIONER GIRARD: The preparation, but not the experience yet?

MRS. DUNCANSON: No, I think too, from the economic point of view our nurses feel that the one way in which they may improve their economic status in the hierarchy of nursing is to secure greater preparation, or assume greater responsibility, which is recognized by increments in salary. We feel there should be a scheme or a system whereby the nurse who wishes to remain at the bedside, and who becomes essentially a specialist in that area can progress in salary increments to a much greater extent than she has at the present time.

COMMISSIONER GIRARD: But is there a problem in trying to do this? Do the nurses that come out of university schools get this added experience when they come out, or do the hospitals kind of push them up immediately in the administrative roles?

MISS SHARPE: Miss Girard, I feel that where there is informed leadership in the hospital field, these students who are graduates from university schools of nursing are given the wise guidance which enables them, after a reasonable length of time in the hospital setting,





Sharpe 9230

to assume positions of increasing responsibility with a background of experience. We know that the availability has tended to hurry them, rush them into positions which their school recognizes has not prepared them, which the young graduate feels she is not prepared for, but the very situation itself has determined to a large extent that.

COMMISSIONER GIRARD: It is a question of lack of prepared personnel, and one will help the other?

MISS SHARPE: Right.

COMMISSIONER GIRARD: On Page 8, Paragraph 19, you say: "At present, there are 62 approved schools of nursing in Ontario of which three are university schools". Of these three university schools are these, well, maybe I should wait and ask this of the university schools, but do they have an integrated program, or are there different programs?

MRS. DUNCANSON: In this Province this reference is to the university schools, who have complete control of the students' experience throughout the entire four or five year period.

COMMISSIONER GIRARD: Then you say: "Fifty-eight are hospital schools and one is an independent school", and you are talking here about the Windsor School?

MRS. DUNCANSON: The Nightingale School.

COMMISSIONER GIRARD: Now, this Nightingale School has also brought a lot of comments and a lot of people would like to know more about it. Would maybe Miss Howard tell us is there any difference between what







Howard 9231

the Nightingale School is trying to accomplish and what was accomplished by the Windsor School?

MISS HOWARD: I think Mrs. Duncanson should answer the question, because she is Director of the School, and we merely make our facilities available for the school.

COMMISSIONER GIRARD: Excuse me, I am sorry.

MRS. DUNCANSON: Speaking on behalf of the Association, I believe that the School is attempting to accomplish the same objectives as were set forth in the Metropolitan School at Windsor. The sponsorship and the financing are quite different in the Nightengale School.

COMMISSIONER GIRARD: Now, if this had been a day school, wouldn't this have proven more to us than what we know already?

MRS. DUNCANSON: May I ask, Mr. Chairman, what Miss Girard means by a day school?

COMMISSIONER GIRARD: By this I mean that we are talking a lot about independent schools where the hospital would not have to provide lodging and room and board, and in this school room and board is provided for these students, is it not?

MRS. DUNCANSON: Speaking as an individual now, yes, that is correct, Miss Girard. The maintenance of the student is provided. However, this is being very closely scrutinized by the sponsoring agency, and we believe that in the very near future there will be a careful investigation really made of the entire financing





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pattern of the school, to determine what are the "true educational costs", and what costs are attributable to the maintenance of the student, with a view to assessing to what degree public funds should probably be used for the maintenance of students under the general heading of the educational cost.

In other words, we are concerned that these costs should be clearly defined, and that the maintenance cost be set forth as such, and decisions reached in some time in the future as to who should be responsible for those.

COMMISSIONER GIRARD: I think, Mrs. Duncanson, my idea was that if the school had not provided room and board we would have had some idea of how much you can recruit students in this type of school. If you were not providing this, it might have given us a clue as to how easy it would be to recruit students in a school which is not a university school, and yet is not giving room and board. I was trying to infer that it would have given us this additional information, because we seem to think that this might be the type of school for the future, this type without the room and board, so if you had not given room and board it might have given us a clue as to what to expect if we go into this type of school in the future. That is what I was trying to get.

On Page 10 you say: "--it is recommended that the preparation of the professional nurse be the responsibility of the universities", in one, and in 2: "That the preparation of the nurse in a diploma school be conducted within a general system of education", and under







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(b) is: "That study be undertaken to determine the most suitable way this may be accomplished". That means that you have no set ideas of where this second person should be trained, in what type of school?

MRS. DUNCANSON: We are aware that studies along this line are being undertaken by our national Association, but in this Province I think that we do not have a fixed opinion as to where this school should be situated, except that we feel the nurses should have access to the same educational opportunities as other professional groups.

COMMISSIONER McCUTCHEON: Is this second-class nurse that you are going to develop going to be called a registered nurse?

MRS. DUNCANSON: Mr. Chairman, we do not consider this person to be a second-class nurse.

COMMISSIONER McCUTCHEON: I take it back.

MRS. DUNCANSON: And again, we feel that terminology, title, qualifications, preparation, education would be embodied in the (b) part of the recommendation.

COMMISSIONER GIRARD: Well, you do state that you are not ready to say, but it has been expressed in quite a number of briefs, that this second person might be trained in a technical school, some kind of a technical school. This has been advanced before. Do you feel that if this were the case, what control would the nursing profession have over the curriculum of this school?



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MRS. DUNCANSON: Under our new legis-  
lation, Miss Girard, we would anticipate that through  
the College of Nurses, we would have very definite con-  
trol over the preparation and qualifications of this  
category.







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4 COMMISSIONER GIRARD: Even if you  
were in a technical school?

5 MRS. DUNCANSON: That is correct. They  
6 would have to meet certain requirements before they  
7 would receive registration, presumably.

8 COMMISSIONER GIRARD: On page 11 there  
9 is a recommendation that states (a) that facilities  
10 in the universities presently offering the basic course  
11 be increased to accommodate at least an additional 1%  
12 of the total number of students per annum and (b) that  
13 early consideration be given by the other three  
14 universities to establishing this course to admit a  
15 total of at least 2% in the first year and an additional  
16 1% per annum until the desirable number is reached.  
17 Dealing with (a) facilities in the universities be  
18 increased to accommodate more students, if these  
19 facilities were available how easy would it be to recruit  
20 students? Before you answer I will tell you why I am  
21 asking this question, because yesterday in the Ontario  
22 Medical Association brief there was a paragraph, I will  
23 read it to you that said:

24 "The main requirement for good quality  
25 "personal health services is a sufficient  
26 "number of highly competent workers in  
27 "this field. To acquire these we must  
28 "look, first of all, to our secondary  
29 "schools to produce sufficient graduates  
30 "with the necessary qualifications to  
"meet the demands of all groups in the  
"province - not just health workers."





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They went on to say:

"When one considers that medicine,  
"nursing, physiotherapy, laboratory  
"technology, dietetics, occupational  
"therapy, hospital medical record  
"service, all require Grade XIII  
"qualifications."

It stated earlier that there were  
only 4,718 graduate in Ontario with Grade XIII. How  
easy is it for nursing to recruit among this group in  
Grade XIII if this group is the only one which nurses  
can be recruited?

MRS. DUNCANSON: Mr. Chairman, under  
the revised education program in this province we as  
an association feel that we should recruit from the  
Grade XIII level of achievement. At the present time  
in our Schools of Nursing in Ontario we have approximately  
23% of our students enrolled who have Grade XIII  
completed, and it would seem that if of our total number  
of students only 3% are enrolled, 3.6 percent are en-  
rolled in the university program then presumably 20%  
of eligible students are enrolled in hospital schools.  
If that percentage can be encouraged through explaining,  
perhaps, first of all, what we believe to be the advantage  
of the preparation at the university level -- I am  
referring now to guidance, and secondly, if they could  
be assisted financially if finance is an impediment to  
proceeding to university it seems that there would be  
immediately available a large number of students who would  
undertake study at the university level, but are not







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4 there at the moment. Further recruitment of this number,  
5 I think, should be increased by perhaps making it  
6 a little beyond the reach of the individual, that is  
7 often a sufficient challenge where you set a standard  
8 high and expect them to meet that and make provisions  
9 whereby they can achieve it financially. I think we  
10 could accomplish more in the way of getting a large  
11 number in. This is tied in, I realize, with the  
12 economic returns to the individual at the practising  
13 level.

14 COMMISSIONER GIRARD: So that if you  
15 had these facilities recruitment wouldn't be a problem?

16 MRS. DUNCANSON: I should think not.

17 COMMISSIONER GIRARD: As it seemed  
18 to be from this brief yesterday, as it seemed to be in  
19 all the medical and paramedical professions. On the  
20 same page 11, paragraph 26 one of the recommendations  
21 read that additional courses be established in Ontario  
22 leading to the Master's and Doctor's degree. How many  
23 courses do you have now in the Master's degree, leading  
24 to the Master's degree?

25 MRS. DUNCANSON: There are two in  
26 Ontario at the present time.

27 COMMISSIONER GIRARD: How many students  
28 are enrolled in this Master degree course?

29 MRS. DUNCANSON: I am sorry, I don't  
30 know. There are 12 enrolled in the University of  
Weston.

MISS RUSSELL: The university at  
Ottawa isn't starting to enrol till September.





Duncanson

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4 COMMISSIONER GIRARD: That is starting  
5 this year. With the other there are 12 enrolled. We  
6 need more Master programs and yet there is one school  
7 giving it and there are only 12 enrolled. Is there any  
8 explanation for this? We are short, we say we are very  
9 short of Master degree programs.

10 MRS. DUNCANSON: Mr. Chairman, I  
11 presume there might be an element of novelty in the  
12 situation, but no doubt, related to this as well is  
13 the financing of the individual through the time that  
14 she would be undertaking her course of study.

15 COMMISSIONER GIRARD: I am glad you  
16 brought this up, Mrs. Duncanson, because I think it is  
17 one of the good reasons, and you refer to it later on.  
18 I wanted to know if this was the main reason. Everybody  
19 says we need more Master degrees and yet when we have  
20 a university giving it we find 12 students, which is  
21 rather low.

22 MRS. DUNCANSON: May I make this  
23 observation too, Miss Girard, we are short of people to  
24 teach persons to become prepared at that level.

25 COMMISSIONER GIRARD: On page 12 you  
26 state how a school of nursing should be set up, immediate  
27 steps can be taken to improve the hospital schools  
28 through the implementation of recommendations which the  
29 Association has set out as follows, and you go on to  
30 state what they are. In the last paragraph: When  
these recommendations are implemented it is considered  
that the cost of maintenance for students should not be  
a charge to the school or be met by public funds. Then







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4 there is reference to Appendix 1 on page 30 and in this  
5 you go on to explain if you take the students' cost per  
6 week as \$18.00 you come up with the figure of about  
7 \$6 million, this is for Ontario only, that you could  
8 use for bursaries and for facilities in improving the  
9 schools. By this you mean if it is not paid by tax  
10 money, if it is not taken out of the school or paid by  
11 public funds this will be paid, you are supposing that  
12 the student will pay her room and board?

13 MRS. DUNCANSON: Yes, this is the  
14 proposal.

15 COMMISSIONER GIRARD: That is the  
16 meaning of this appendix on page 30?

17 MRS. DUNCANSON: That is correct.

18 COMMISSIONER GIRARD: So this comes  
19 back to what I asked you before, that we don't have  
20 any experience yet. This \$18.00 is approximate, isn't  
21 it? The \$18.00 a week is an arbitrary figure?

22 MRS. DUNCANSON: It is based on the  
23 university figures, what they charge for maintenance.  
24 Our figures from the various school indicating their  
25 maintenance costs vary so considerably that it is not  
26 possible to take one figure as a direct example.

27 COMMISSIONER GIRARD: But we have  
28 no schools yet that have admitted students without giving  
29 them room or board that we could use?

30 MRS. DUNCANSON: University schools  
have, but not the hospital schools.

COMMISSIONER GIRARD: I am talking  
about the hospital schools. That is why I made the point



There is reference to paper in a number of places  
and on to explain the nature of the  
week as 118.00 per week with the paper of about  
25 million, this is for Ontario and that was about  
use for business and no facilities in any other  
schools. By that you mean it is not a school  
school, it is not taken out of the school and it is  
private funds that will be set, you are supposed to  
the student will pay for room and board.

1957, March 19th, Vol. 1, this is the

proposal.

1957, March 19th, Vol. 1, this is the

meaning of this proposal on page 11.

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1957, March 19th, Vol. 1, this is the

back to what I asked you before, that we don't have  
any experience yet. This is a big question, isn't  
it? The 118.00 a week is an average figure.

1957, March 19th, Vol. 1, this is the

University of Toronto, what they did was to

Our figures from the various schools indicate that

maintenance costs vary so considerably that it is not

necessary to take one figure as a yardstick.

1957, March 19th, Vol. 1, this is the

schools yet that have no listed students at all, and

then how can we find that we don't have?

1957, March 19th, Vol. 1, this is the

have, but not the hospital school.

1957, March 19th, Vol. 1, this is the

About the hospital school. It is the school that



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4 about the Florence Nightingale School, having this in  
5 mind.

6 Then, on the same page you make this  
7 recommendation that bursaries be made available in  
8 sufficient amounts to remove financial impediment for  
9 suitable candidates in basic nursing courses and post-  
10 graduate studies in university. Would you have offhand  
11 some kind of figure you would like to give the Commission  
12 as being an adequate amount for bursaries in these two  
13 categories?

14 MRS. DUNCANSON: Mr. Chairman, we don't  
15 have that information readily available, but I am sure  
16 we would be pleased to supply it if this would be of  
17 assistance to you.

18 COMMISSIONER GIRARD: What would you  
19 consider an adequate bursary for the student in the  
20 basic nursing course and in the post-graduate studies.  
21 All the briefs on nursing have recommended bursaries.  
22 I think it would be helpful if someone gave us a certain  
23 amount, told us what the amount should be, an adequate  
24 amount.

25 MRS. DUNCANSON: We would be pleased  
26 to attempt to do this, Miss Girard.

27 COMMISSIONER GIRARD: And how many  
28 as Commissioner Firestone said, the number of scholar-  
29 ships you would recommend. I have two or three briefs  
30 in my mind and there are some appendices in some briefs  
that do give that. I think it is coming later. On  
page 14 you make the statement that a number of students,  
and there is an appendix on page 26, the number of







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4 students in teachers' colleges has doubled between 1954  
5 and 1959 whereas the number of students in nursing has  
6 not come anywhere close to that. Do you have any idea  
7 why they have doubled in the teaching profession and  
8 not in nursing? You have made some enquiry on this  
9 because you have the appendix on this on page 26. The  
10 source is the Ontario Department of Education. There  
11 is nothing here but the figures and the figures show  
12 it has doubled, teachers' colleges have doubled their  
13 enrolment in six years.

14 THE CHAIRMAN: They picked up a thousand  
15 men in doing that.

16 COMMISSIONER GIRARD: Why aren't we  
17 picking up a thousand men?

18 MRS. DUNCANSON: I believe the number  
19 of students enrolled in teachers' colleges has actually  
20 almost increased four-fold.

21 COMMISSIONER GIRARD: It is two-fold  
22 in these six years, maybe four-fold in the total.

23 MRS. DUNCANSON: In the ten year  
24 period.

25 COMMISSIONER GIRARD: It is two-fold  
26 in six years.

27 MRS. DUNCANSON: The nursing group  
28 has gone along at a fairly constant percentage of the  
29 eligible people.

30 COMMISSIONER GIRARD: The Chairman  
did give one good reason. Could we elaborate on this  
reason. Why are we not picking up more men in nursing?

MRS. DUNCANSON: Mr. Chairman, I would





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hazard a guess it is related to the economic status.

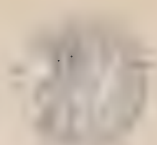
COMMISSIONER GIRARD: You have nothing  
against men?

MRS. DUNCANSON: Perhaps it is the  
attitude of society to men undertaking this type of  
profession, but from within the profession there is  
certainly no reluctance to receive and accept them.

COMMISSIONER GIRARD: I say this  
because in the Province of Quebec we cannot have them  
even if we wanted to. Here you are free to have them.  
How many male nurses do you have in Ontario?

MRS. DUNCANSON: May I enquire --  
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COMMISSIONER GIRARD: -- Would you like to see this number go up?

MRS. DUNCANSON: Our Association would go on record in support of increasing this number.

COMMISSIONER GIRARD: On page 15 the recommendation is that a study of the utilization of nurses be undertaken by the Royal Commission on Health Services. I am happy to say that this is being done. You probably all know that the Commission is studying the utilization of nurses.

On page 16, the last recommendation - not the last -

"Pending a study of utilization of nurses, health agencies review present policies with a view to improving utilization locally."

I would like to state again here something that was brought up in the Ontario Medical Association brief yesterday and that I think it's related to this and see what the nurses would like to say about it.

In paragraph D in Appendix 15, page 243 of the Ontario Medical Association brief it says:

"The increasing tendency to divorce nurses' education and training from practical medical aspects towards administrative aspects is fast leading to an expensive manpower problem. This is necessitating the training and hiring of nurses' aides and special nursing technicians to





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do actual nursing procedures, while the R.N. is devoting her time to administration, form-filling, charting, etc., and is becoming of less direct assistance in the care and management of the sick. The whole orientation of post-graduate nurses' training is compounding this expensive error in emphasis, in which 'Teamwork' is the euphemism used to cover lack of individual player participation."

The following paragraph says:

"There is growing evidence that hospitals are being organized for the benefit of employees rather than for patients. Thus it is insisted that nurses must have two days off each week, and since most of them want this at the weekend, there is strong pressure to close operating rooms on Saturdays. This is further adding to the cost and inefficiency of hospital services."

So that ties up with the utilization paragraph that you have here. Are there any comments on this?

MRS. DUNCANSON: I don't know whether this would be considered as an official comment or not.

COMMISSIONER GIRARD: Are all the nurses insisting to have their two days off on weekends?

MRS. DUNCANSON: I can't think that this







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is the case.

COMMISSIONER GIRARD: Are operating rooms closed on Saturdays just because of nurses?

MRS. DUNCANSON: Not just because of nurses, no, Miss Girard.

COMMISSIONER McCUTCHEON: Surgeons go away too?

MRS. DUNCANSON: Surgeons go away too.

COMMISSIONER GIRARD: I just brought this up; I think this is only fair for the nurses to say something on this and if you don't wish to comment, it is all right. I just wanted to bring it up.

MRS. DUNCANSON: Mr. Chairman, may we enquire for any supporting evidence for this statement?

COMMISSIONER GIRARD: Yes. Mrs. Duncanson, you do not have to answer this. I just brought it up. I think you should know what we have to work on. What we have to be careful of. What were the comments that people have about us. See if there is anything in them. If there is, what are we going to do about it? I brought it up because you are yourself talking here about good utilization and this comes into good utilization. I think we all know in the nursing profession we have our share to do in this. I did not bring this up for a controversial discussion.

MRS. DUNCANSON: May I ask if one of our representatives, who is a Director of Nursing in a large hospital, would care to comment on this statement?

MISS HOWARD: Mr. Chairman, I would just like to make one or two comments. One is that





Howard

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nursing service plan for seven-day coverage, 24 hours a day for seven days and therefore, the weekends are covered.

Secondly, there are nurses who can only work weekends who are utilized on a part-time basis.

Thirdly, I would think the utilization study would prove that we could make better use of the services of the nurses we have on the weekends if some other people worked weekends so we wouldn't be doing their jobs.

COMMISSIONER BALTZAN: Would you care to give them by name?

COMMISSIONER GIRARD: This is a good answer, and I think that no one thinks that this was brought up as a reflection on anybody. It's just that we all have common problems and if we don't bring them out in the open, we cannot solve them and on this I will take a bow and let my confreres have something to say now.

THE CHAIRMAN: Thank you, Miss Girard. Mrs. Duncanson, in connection with the legislation passed at the recent session of the Ontario Legislature, what you are setting up is a licensing body similar to the College of Physicians and Surgeons and applicable to the school of nursing. Has this been done or is it being done, do you know, in any other province?

MRS. DUNCANSON: Mr. Chairman, I am not aware of it being done in any other province or that it has been done. We would hope that eventually we might have the provision for licensing but at the present time we do not have that power.







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THE CHAIRMAN: Now, when your Act is proclaimed and comes into force, all those practising as nurses, registered nurses in Ontario, will automatically have the right to be registered under the Act?

MRS. DUNCANSON: Yes, that is correct, sir.

THE CHAIRMAN: From then on to become entitled to be registered would be by whatever regulations are made?

MRS. DUNCANSON: Yes.

THE CHAIRMAN: Do you see the enactment of this legislation as impeding the mobility of nurses from one province to another? Your registered nurse may move very freely at the moment. Will this type of provincial legislation, which is a new idea in your nursing set-up, lead to the same situation that we have had, say, with the various law societies where it was, for a time, very difficult, and still is as a matter of fact, very difficult to move from one province to another?

MRS. DUNCANSON: May I ask Dr. Gray to respond to that?

DR. GRAY: Mr. Chairman, at the present time, of course, there is reciprocity in nursing registration between the provinces and it is not expected that this will be altered in any way by the new legislation, unless one or other of the other provinces refuse to admit nurses registered under the Ontario Act.

I do not think there is any intention of using this legislation to exclude nurses from other provinces becoming registered in Ontario as they can today.





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THE CHAIRMAN: Dr. Van Wart?

COMMISSIONER VAN WART: Mrs. Duncanson, you may answer these or ask somebody else. First, for clarification, is the term "diploma nurse" and "nursing assistant" synonymous?

MRS. DUNCANSON: Not at the present time, sir, no.

COMMISSIONER VAN WART: Well, I will confine my remarks then to the nursing assistant. Have you any idea how many, or the total number of nursing assistants, are employed in hospitals in Ontario?

MRS. DUNCANSON: We have the figure of 3,000.

COMMISSIONER VAN WART: That would be what percentage of the nursing staff in the hospitals of Ontario?

MRS. DUNCANSON: May I ask Miss Sharpe to respond to that question?

MISS SHARPE: Sir, as of December 31st, 1961, the figure given at that date was 12,926 registered nurses employed in the hospitals of this province.

COMMISSIONER VAN WART: And the diploma or the nursing assistant would be extra to that?

MISS SHARPE: Right.

COMMISSIONER VAN WART: That would be 20%?

MRS. DUNCANSON: One to four.

COMMISSIONER VAN WART: Of the nursing staff?

MISS SHARPE: Right.







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COMMISSIONER VAN WART: Quite a large body for the nursing staff. Do you consider the nursing assistant essential to the hospital program? Nursing program?

MRS. DUNCANSON: Mr. Chairman, our Association sponsored the development of the nursing assistant in its initial stages and we have consistently believed that they have a place in the nursing family.

COMMISSIONER VAN WART: Is the Registered Nurses' Association interested in the progress of the nursing assistant?

MRS. DUNCANSON: Very definitely, sir. We have provided for some professional guidance for this group and in this legislation, which has recently been enacted, there is provision for the continuing interest of the certified nursing assistant, in that legislation.

COMMISSIONER VAN WART: What promotions are available for nursing assistants after she gets her diploma, and so on, and works in your hospital? What promotion is available for her?

MRS. DUNCANSON: Mr. Chairman, at the present time there is no promotion out of the category of nursing assistant. There are possibilities for her to achieve a larger return in increments or in salary, but there is no provision whereby she can advance beyond the state of her certified nursing assistant, unless, of course, she has the education and should commence in another program.

COMMISSIONER VAN WART: Has your Association given consideration to the use of trained technicians



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essential to the hospital program. It being

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and assistants in the operating room in place of the registered nurse assisting in the operating room?

MRS. DUNCANSON: Our Association, sir, has recognized two categories of nurses: the registered nurse and the certified nursing assistant and we have not gone on record at any time in regard to the question that you have asked.

COMMISSIONER VAN WART: Is it, under your present system, impossible for nursing assistants to be promoted to an operating room technician assistant; that is, as first assistant to operations?

MRS. DUNCANSON: May I ask Miss Sharpe if this is in effect in any part of the province?

MISS SHARPE: In answer to the question, Mr. Commissioner, we would say that we would not encourage the nursing assistant to become an operating room technician, whereas, we would encourage the preparation of a person to become an operating room assistant who was not either a registered nurse or a certified nursing assistant.

The principle for such a person being prepared to act in that capacity is being promoted and supported.

COMMISSIONER VAN WART: Would you be in favour of training technicians, such as we have the technicians in the x-ray department, specially trained to become operating technicians or assistants?

MRS. DUNCANSON: Our Association has not given consideration to this question.

COMMISSIONER VAN WART: Do you feel there is a field for trained technicians such as radiological







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technicians, and so on, in these positions? In the operation position?

MRS. DUNCANSON: I do not feel that I can answer that question on behalf of the Association, sir.

COMMISSIONER McCUTCHEON: Didn't you say that was being supported, Miss Sharpe?

MISS SHARPE: That is being supported in the hospital field, yes.

COMMISSIONER VAN WART: Have you any such person in the operating room at the present time?

MISS SHARPE: We have, sir.

COMMISSIONER VAN WART: As first assistant?

MISS SHARPE: The category of assistant is not given first or second, but there are persons who are functioning in several of the hospitals of this province as surgical technicians or as operating room technicians and are serving as, what is being done in many other places, a scrub nurse.

In other words, they are people with qualifications in that area who are doing the job that the registered nurses, with additional qualifications are doing in other places and doing it very satisfactorily, sir.

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4 COMMISSIONER VAN WART: Do you feel  
5 your nursing assistants can be promoted to become one  
6 of these technicians?

7 MISS SHARPE: We would not consider  
8 it a promotion. We consider that the certified nursing  
9 assistant is working in the role of a nurse and as a  
10 very satisfactory one. We feel the other requires  
11 technical skills and possibly some of the skills that  
12 the certified nursing assistant needs in her more  
13 general approach to nursing but are not necessary in  
14 the purely technical approach.

15 COMMISSIONER VAN WART: A nursing  
16 assistant then is not available for use in the operating  
17 rooms?

18 MISS SHARPE: She is available and  
19 there are places where she has been used.

20 COMMISSIONER VAN WART: Do you feel  
21 that is desirable?

22 MISS SHARPE: No.

23 COMMISSIONER VAN WART: On what basis?

24 MISS SHARPE: We feel a technical  
25 assistant in the operating room is going to be prepared  
26 to do a purely technical piece of work. We feel the  
27 certified nursing assistant has a contribution to make  
28 to the nursing care of patients which requires a type  
29 of preparation, length of preparation which is not  
30 required in the preparation of the technical assistant.

COMMISSIONER McCUTCHEON: Would you  
regard it as a down-grading of a nursing assistant to  
make her a technician?







Sharpe

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MISS SHARPE: Well, it is different.

COMMISSIONER VAN WART: I use that as an example of what I thought was a promotion for the nursing assistant but you do not seem to think it is a promotion?

THE CHAIRMAN: What Miss Sharpe is saying is that it is a waste of part of her preparation.

COMMISSIONER VAN WART: Then the registered nurse is a waste in the operating room too.

Number four of your summary, there is one sentence halfway down "until a suitable diploma program may be established". Is that for the, so to speak, under-graduate training of the diploma nurse, the program they are speaking of or is there something else?

MRS. DUNCANSON: We have predicted the future development of two categories of nurses, the person who is prepared within the university and the person who is prepared at the diploma level. However, until such time as this type of preparation is available in sufficient amounts to prepare the number we require, we are saying until this can be established the present hospital schools of nursing and the training program for the nursing assistants must continue.

COMMISSIONER VAN WART: Well, who will establish this program? You are speaking of "until a suitable diploma program may be established", who have you in mind that will establish this program?

MRS. DUNCANSON: We have indicated on page 3 in our recommendation 5 that study be undertaken to determine the most suitable way that this may be accomplished. As I intimated earlier, we are aware that





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our national association is carrying out a very intensive study along this line and we would, as a professional provincial association be quite supportive to the recommendations that would come out of that study.

COMMISSIONER VAN WART: The idea is it is a pre-diploma course you are thinking about, that you establish a diploma nurse -- it is the pre-diploma study?

MRS. DUNCANSON: No, this would be a program leading to a diploma in contrast to a degree.

COMMISSIONER VAN WART: Well then, have you given consideration to a post-graduate course for these diploma girls to improve their knowledge, a course of that nature?

MRS. DUNCANSON: This is a prediction.

COMMISSIONER VAN WART: That is what I mean, are you thinking along that line too?

MRS. DUNCANSON: At the present time we believe that the efforts of the educational institutions should be directed towards the preparation either at the degree level or at the diploma level and in our present situation where we are attempting to build on our current diploma program so persons may achieve degree status, there is such a wide variation in the diploma preparation that they universities, I am sure, must find it very difficult to find a common level of teaching whereby diploma nurses may proceed to degree courses. I think, hopefully, we would anticipate that the nurse would decide before she entered the program that she wished to be prepared either at the diploma







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4 level or at the degree level and if it was at the degree  
5 level the diploma preparation would be essentially  
6 commencing from the beginning towards the attaining of  
her degree.

7 COMMISSIONER VAN WART: A question  
8 along another line; do you feel that the nursing  
9 assistants should be a subdivision of your organization  
10 rather than have them as a separate independent nursing  
11 organization?

12 MRS. DUNCANSON: Mr. Chairman, at the  
13 present time in order that we may retain our national  
14 and international relationships it is required that we  
15 be an association of registered nurses. Therefore, it  
16 would not be possible for us to have a subdivision of  
persons other than registered nurses.

17 COMMISSIONER VAN WART: Well then,  
18 who speaks for the 300,000 nursing assistants of Ontario?

19 MRS. DUNCANSON: They have their own  
20 association and in relation to minimum standards of  
21 education their voice will be heard through their  
representative on the council of nursing.

22 COMMISSIONER VAN WART: That is to say,  
23 they will not apply through your organization, they are  
24 separate, they can develop their own philosophy and  
25 their own everything separate and distinct from your  
26 organization?

27 MRS. DUNCANSON: That is correct, sir.

28 COMMISSIONER McCUTCHEON: Subject to  
the jurisdiction of the College of Nurses?

29 COMMISSIONER VAN WART: Yes, they come  
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3 under the College of Nurses, a separate organization.

4 MRS. DUNCANSON: They do not actually  
5 come under the College of Nurses. They are, as an  
6 association, presumably concerned with the social and  
7 economic welfare of their members the same as the  
8 Association of Registered Nurses.

9 COMMISSIONER VAN WART: Their relation  
10 with the college is the same as your relation?

11 MRS. DUNCANSON: Yes.

12 COMMISSIONER VAN WART: That is, you  
13 are developing two organizations of nursing now in your  
14 province instead of having one organization control  
your nursing?

15 MRS. DUNCANSON: We have one associa-  
16 tion dealing with the social and economic aspects of  
17 the College as a statutory body dealing with minimum  
18 standards.

19 COMMISSIONER VAN WARD: The point I  
20 am making, in your hospitals now you will have two  
21 organizations, the registered nurses association and  
22 the so-called diploma nursing organization in the  
hospital, that will be the situation?

23 MRS. DUNCANSON: I am sorry, I do  
24 not understand the question at this point.

25 COMMISSIONER VAN WART: Well, if the  
26 nursing assistants have an organization of their own  
27 and the registered nurses have an organization of their  
28 own, therefore, you have two organizations of nurses  
in the hospital?

29 MRS. DUNCANSON: In Ontario it is not  
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4 mandatory that every registered nurse or every certified  
5 nursing assistant belong to their associations, it is  
6 voluntary. We could not assume that within a hospital  
7 every registered nurse or every certified nursing  
8 assistant would be necessarily a member of her organiza-  
9 tion.

10 COMMISSIONER VAN WART: The fact  
11 still remains you will have two organizations in your  
12 hospital.

13 MRS. DUNCANSON: We will have two  
14 categories of nurses in the hospital.

15 COMMISSIONER VAN WART: Organized?

16 MRS. DUNCANSON: They will not be  
17 organized within the hospital, they will be organized  
18 provincially.

19 COMMISSIONER VAN WART: I will not  
20 pursue it any further, that is all, thank you.

21 COMMISSIONER FIRESTONE: Mrs. Duncanson,  
22 in your recommendation 1 you say, and I quote:

23 "Complete health care be made available

24 "to all Canadians regardless of their

25 "financial condition."

26 What is your definition of complete health care?

27 MRS. DUNCANSON: We have interpreted  
28 this to mean hospital care, medical care, nursing care,  
29 home care.

30 COMMISSIONER FIRESTONE: Are you  
concerned with the physical health as well as the mental  
health?

MRS. DUNCANSON: That is correct.



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4 COMMISSIONER FIRESTONE: And you are  
5 concerned with preventive medical care services as well  
6 as curative?

7 MRS. DUNCANSON: Yes.

8 COMMISSIONER FIRESTONE: And when you  
9 speak of nursing you include nursing in the hospitals  
10 and outside of hospitals?

11 MRS. DUNCANSON: We visualize nursing  
12 as embracing the promotion of health, the maintenance  
13 of health, the care of persons while they are ill and  
14 their rehabilitation to an optimum state of health  
15 following their illness.

16 COMMISSIONER FIRESTONE: Both inside  
17 and outside the hospital?

18 MRS. DUNCANSON: Yes.

19 COMMISSIONER FIRESTONE: Thank you  
20 very much, that is a very clear definition. "Making  
21 available to all Canadians regardless of financial  
22 conditions", does this mean that you are endorsing the  
23 principle of prepayment, people prepaying for such  
24 medical care services and other health care services?

25 MRS. DUNCANSON: We believe the method  
26 by which this may be accomplished is a matter of  
27 government concern.

28 COMMISSIONER FIRESTONE: Well, I just  
29 wonder. I was under the impression that this Royal  
30 Commission was set up to find out what people think  
about it and we are here to obtain this information  
and then pass on some recommendations to the government.  
We are really coming to the public at large and







Duncanson

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4 organizations to get their views. I was of the  
5 impression that it was not primarily a government  
6 concern, it was a concern of the people of Canada and  
7 we are here to get the views of people like you.

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8 COMMISSIONER McCUTCHEON: Is the  
9 answer that you made this very wide, all-embracing  
10 recommendation but you have not given any thought as  
11 to how it may be done?

12 MRS. DUNCANSON: Mr. Chairman, our  
13 Association has not recorded any policy by which this  
14 might be made available.

15 COMMISSIONER FIRESTONE: Would it  
16 be possible, Mrs. Duncanson, for your organization to  
17 give a little thought to it and let us know at a sub-  
18 sequent time what your views are on how this objective,  
19 which apparently is a very desirable objective and  
20 which you support, can be achieved?

21 MRS. DUNCANSON: Yes, we would accept  
22 this as a request.

23 COMMISSIONER McCUTCHEON: What your  
24 views are, if any.

25 COMMISSIONER FIRESTONE: Do I under-  
26 stand then that you would be prepared to have your  
27 group consider this question as to how this objective  
28 which you have stated in paragraph 1 can be put into  
29 practice and that such views may be communicated to us,  
30 at your convenience, in the form of a written submission  
or letter to our secretary? Is that acceptable to  
you?

MRS. DUNCANSON: Yes, I am sure we can





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study this.

COMMISSIONER FIRESTONE: "And you will let us know the result of your study?"

MRS. DUNCANSON: That is correct.

COMMISSIONER FIRESTONE: Thank you very much.

COMMISSIONER STRACHAN: This pertains to the first paragraph; I think the normal conception of a nurse is that individual who gives nursing care, bedside nursing care to a patient and that group must form a majority of the nursing profession. Yet, I notice in your first paragraph of this that this brief has been prepared by a committee of association members representing administration in nursing services and education in university and hospital schools, so to use your own phraseology the morning, by the hierarchy of nursing. Has this been done to the exclusion of the grass roots of nursing?







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MRS. DUNCANSON: Mr. Chairman, with the exception of one prediction, to which I have alluded, we have been reiterating policies which have been established by our Association over a period of time, and within the by-laws of our Association it is quite possible for an individual to be heard, either as an individual or through small local groups of our organization functioning at chapter level, and district level or indeed at the time of our Annual Meeting any member of our Association has the privilege of voicing her opinion, and this presentation is a reflection of policies that have been developed through this procedure.

COMMISSIONER STRACHAN: I am quite aware of the fact that any individual can appear before this Commission, but why you so specifically state that this brief has been prepared by these two groups is difficult to understand.

MRS. DUNCANSON: You will note, sir, in the third paragraph that we have thanked those persons who have sent expressions of opinion to us. The Districts were invited, and indeed asked to discuss this at the level of the individual nurse, and such representations were made and received and considered at the time that this brief was being prepared.

COMMISSIONER STRACHAN: Then it is to be hoped that this represents the expression of all nurses in the Province of Ontario, even though prepared by these two groups.

MRS. DUNCANSON: Mr. Chairman, the policies of our Association have to be approved by the



1. Introduction

The purpose of this report is to analyze the problem of the distribution of the population of the United States in 1950. We have found that the population of the United States in 1950 was 150,000,000. This is a significant increase from the population of 120,000,000 in 1940. The increase in population is due to a number of factors, including a high birth rate, a low death rate, and immigration. The distribution of the population is also changing. The population is becoming more concentrated in the eastern half of the country, and more concentrated in the urban areas. This is due to a number of factors, including a high birth rate, a low death rate, and immigration. The distribution of the population is also changing. The population is becoming more concentrated in the eastern half of the country, and more concentrated in the urban areas. This is due to a number of factors, including a high birth rate, a low death rate, and immigration.

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membership at large, and in outlining these policies we are simply stating what has already been approved by our Association in previous meetings.

COMMISSIONER STRACHAN: I think you may be aware that we have some evidence where a presentation has been made by more or less an individual, and then refuted by organizations within that jurisdiction. That is the reason I asked this question.

THE CHAIRMAN: There is no suggestion of that in this Province, is there, Dr. Strachan?

COMMISSIONER STRACHAN: None at all, well, I am hoping not.

In your fourth recommendation you speak of the professional nurse. I presume that would be the nurse with a degree, as compared to one with a diploma, or a registered nurse. Does this take away the professional status of the registered nurse, by using this term? You speak of the preparation of the professional nurse.

MRS. DUNCANSON: Our interpretation, sir, of the word professional means a person who is responsible for establishing standards, for assessing needs, for developing plans to meet needs; indeed, to evaluate whether that plan has been effective or not.

COMMISSIONER STRACHAN: As against the ordinary, if you will excuse the term, registered nurse?

MRS. DUNCANSON: We would still expect that the diploma nurse would be capable of exercising independent judgment, and certainly behaving in a professional manner, but that the standards of the profession,







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the education, would be to a large extent determined by this person, who presumably would have a better education and a broader understanding of the requirements of our society's health needs in this Province.

COMMISSIONER STRACHAN: Well, by this paragraph you rather suggest that they should be a graduate of a university, do you not?

MRS. DUNCANSON: That is correct, sir, yes.

COMMISSIONER STRACHAN: And I return to my original question. Is the graduate nurse of a university the professional nurse, and the registered nurse the non-professional?

MRS. DUNCANSON: Mr. Chairman, we have not used the term non-professional deliberately. Again, trying to exemplify our interpretation of the word professional in that it represents to us the determining of standards to meet the needs as represented by our society, and this we believe requires the most highly educated, and most broadly educated member of nursing, of the nursing family, and we believe that the person who graduates from the university is the person who can give this leadership to nursing needs to take its rightful place as a professional in our society.

COMMISSIONER STRACHAN: And she will be known as a professional nurse?

MRS. DUNCANSON: She will have a degree in nursing. We will not, again though I cannot speak for the Association, but it is not anticipated that that person would have the nomenclature of professional





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nurse, that she would be a nurse the same as a person prepared from a diploma program would be a nurse, but it would be in the breadth and depth of her preparation and understanding of the health needs of the society the distinction would exist.

COMMISSIONER STRACHAN: Turning to the Nurses' Act, Paragraph 2 says: "The Council shall be composed as follows, A.", and then "(b)members elected by the Registered Nurses of Ontario in accordance with the regulations; (c) members appointed by the Registered Nurses Association of Ontario". What is the differentiation there?

MRS. DUNCANSON: Mr. Chairman, in this Province not all registered nurses are required to be members of the Association. That is part of the distinction in this area. However, every nurse in this Province who is registered should have and will have some responsibility for electing persons who will be speaking on her behalf in the affairs of the College.

Again, these are relating to minimum standards of education to a limited degree practice, to discipline and to registration.

COMMISSIONER STRACHAN: Whether she is a member of the Registered Nurses' Association or not?

MRS.DUNCANSON: That is correct. It is quite probable that a large percentage of the persons elected by the registered nurses of Ontario will be members of the Association, but the official representation on the Council from the Association will be by members appointed by the Association.







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THE CHAIRMAN: Thank you, Mrs.

Duncanson and your associates, Dr. Gray. You have been very helpful to us this morning, and we appreciate the thought and consideration that went into the preparation of your brief.

MRS. DUNCANSON: Mr. Chairman, we have appreciated the privilege of presenting it.

THE CHAIRMAN: We will take a few minutes, and resume then with the Canadian Conference of University Schools of Nursing.

---A short recess.



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THE CHAIRMAN: Ladies and gentlemen,  
if we could come to order we will proceed.

DR. JOBIN: Mr. Chairman, the following  
submission will be presented by the Canadian Conference  
of University Schools of Nursing. The exhibit will be  
known as Exhibit 248. The brief will be presented by  
Dr. Chittick.

S U B M I S S I O N O F  
THE CANADIAN CONFERENCE OF UNIVERSITY SCHOOLS OF NURSING

APPEARANCES:

DR. RAE CHITTICK,  
Director, School for Graduate Nurses,  
McGill University

SISTER DENISVE LEFEBVRE,  
Director,  
Institut Marguerite d'Youville,  
Montreal.

MISS JENNY WEIR,  
President,  
Canadian Conference of University  
Schools of Nursing.

MISS MOYRA ALLEN,  
Chairman, Eastern Region,  
Canadian Conference of University  
Schools of Nursing.

---EXHIBIT NO. 248: Submission of The Canadian Con-  
ference of University Schools of  
Nursing.







Chittick 9267

DR. JOBIN: Dr. Chittick, would you please introduce your members?

DR. CHITTICK: Honourable Chairman, and members of the Commission, it is my privilege this morning to present the brief from the Canadian Conference of University Schools of Nursing. I should like to introduce the members of my Committee who are prepared to help me in presenting this material this morning. On my right is Miss Jenny Weir who is President of this organization, and also Director of Nursing in Queen's University, the School of Nursing at Queen's. On my left is Sister Lefebvre who is a member of our Association and Director of the Institut Marguerite d'Youville at Montreal which is associated with the University of Montreal.

THE CHAIRMAN: Sister Lefebvre is an old friend.

DR. CHITTICK: I am sure she is. She is very well-known across Canada.

COMMISSIONER GIRARD: But a young person.

THE CHAIRMAN: They are all young.

DR. CHITTICK: And on my far left Miss Moyra Allen, Chairman, Eastern Region and she is an associate professor of nursing at McGill.

THE CHAIRMAN: Dr. Chittick, you may sit down if you prefer.

DR. CHITTICK: Thank you. My directive, sir, was to read the summary of the recommendations. I have read a good many of the briefs from the nursing



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associations and also listened to the very fine brief presented by the Registered Nurses' Association of Ontario this morning. I am struck, as I am sure you are by the similarity of the recommendations in the briefs across the country. I think what we are trying to do this morning is to point out our point of view as a group of university people, but also we are members of the Canadian Nurses' Association, and all of us are members of the individual provincial associations so that this brief will reflect the opinions of these groups and also the thinking within the universities. I shall read the summary of recommendations. This brief was prepared by a special committee and was sent out to all members of the Association who, if they wished to do so, sent back comments. The brief was then rewritten in the light of these suggestions.

COMMISSIONER McCUTCHEON: You got to the grass roots.

DR. CHITTICK: We got back to our members, anyway.

COMMISSIONER GIRARD: And they are not the grass roots.

DR. CHITTICK: The Canadian Conference of University Schools of Nursing suggests that the great shortage of nursing in Canada could be alleviated by better preparation of nurses. At the present time advanced preparation for nursing is centred in university schools, but the number of nurses with university preparation is so small that this group has made almost no impact on the present system of providing nursing services. The Canadian







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Conference of University Schools of Nursing makes the following recommendations to improve this situation.

I. That definite steps be taken to prepare at least one-quarter of nurses in university programs.

II. That the present system of Federal-Provincial bursaries be reviewed. It is suggested that the number of bursaries and the amount of each bursary be increased, and that the present obligations required by bursary recipients be made less restrictive.

III. That the Federal Government, as the largest single employer of nurses in Canada, recognize that university preparation is necessary for positions of head nurse, supervisor, teacher and administrator, and that the Federal Government show leadership in employing persons in these positions with appropriate university preparation. This leadership should consider a much higher range of salaries for senior positions and generous bursaries for university preparation.

IV. That the Federal Government encourage provincial authorities responsible for the administration of hospital insurance to recognize that university preparation is essential for positions of head nurse, supervisor, teacher and administrator, and that they make provisions for financial assistance to prepare nurses for these positions.





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That Departments of Health encourage continuing education of public health nurses within the university, and that they recognize that the preparation for public health nursing is at least a baccalaureate degree.

VI. That the Royal Commission on Health Services give careful consideration to the recommendations in the Submission presented by the Canadian Nurses' Association.

Those constitute our recommendations and we would be pleased to discuss them further or to answer any questions.

THE CHAIRMAN: Thank you very much, Dr. Chittick. The opening sentence, the Canadian Conference of University Schools of Nursing suggests that the great shortage of nursing in Canada -- is it a fact that there is a great shortage of nursing or nurses in Canada in the light of the statistical information we had that in the Province of Ontario that your ratio is the second highest in Canada, and that ratio is in a very high bracket so far as the world-over is concerned.

DR. CHITTICK: Do you wish me to reply?

THE CHAIRMAN: If you will. I want your views on that.

DR. CHITTICK: I think it is a very important question. I think many people in the nursing profession agree there isn't really such a large shortage as it would appear.

THE CHAIRMAN: I am not suggesting that





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That legislation of health care is continuing  
education of public health nurses and in the  
university, and that the recognition that the  
preparation for public health nursing is at  
least a two-year program.

V.

And the Royal Commission on the Canadian  
Nurse's Association in 1937 recommended that  
in the future the preparation for the nursing  
profession should be a two-year program.

VI.

In a committee on the nursing profession  
and we would be pleased to discuss them further on the  
nurses and physicians.  
The Royal Commission on the Canadian Nurse's  
Association in 1937 recommended that the preparation  
for the nursing profession should be a two-year  
program.

At University of Toronto at the time, suggests that the great  
shortage of nursing in Canada -- is in a fact that there  
is a great shortage of nursing in Canada in the  
light of the statistical information we have that the  
Province of Ontario has the second highest  
in Canada, and that there is a very high percentage so  
far as the workforce is concerned.

Q. Now, I wish to ask you to  
reply?  
A. Yes, I will. I want  
your views on that.  
Q. On this, I want to ask a very  
important question. I think many people in our nursing  
profession agree there is a very high percentage of  
as a result of that.  
A. Yes, I agree. I am not sure that



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there are not shortages in certain segments, that kind of thing. They are accentuated here and perhaps less there.

DR. CHITTICK: In other places.

THE CHAIRMAN: The overall picture that there is a great shortage of nurses in Canada, is that true?

DR. CHITTICK: No, I think we could say that isn't true. We know there are many wards closed in hospitals, and whether or not these are closed because of shortages of nursing or for some other reason, I don't

know. THE CHAIRMAN: Some other administrative, budgetary reason.

DR. CHITTICK: That is right. We haven't by any means the highest ratio of nurses for the population. I think in the Canadian Nurses' Association brief we stand down about tenth in relation to other countries in the world, but the difference isn't very great. We do seem to have a very high ratio of nurses to population.

THE CHAIRMAN: Going from there no one would suggest or accept from what is said that you don't have a shortage of university-trained nurses.

DR. CHITTICK: We do have. We have a very large shortage.

THE CHAIRMAN: Your primary interest is in that field.

DR. CHITTICK: Yes.

THE CHAIRMAN: Dr. Baltzan.

COMMISSIONER BALTZAN: Mr. Chairman,

There are not changes in certain segments, that kind of thing. They are somewhat more and perhaps less

THE CHAIRMAN: The overall picture that there is a great number of nurses in Israel, is that true?

MR. CHAIRMAN: No, I think we could say that isn't true. We know there are many wards closed in hospitals, and when we go to these wards and see the of all images of nursing or for some other reason I don't

MR. CHAIRMAN: Some other administrative knowledge, satisfactory reason.

MR. CHAIRMAN: That is right. We haven't by any means the highest number of nurses for the population. I think in the American Nurses' Association that we stand down about 10% in relation to other countries in the world, but the difference isn't very great. We do seem to have a very high level of nursing education.

MR. CHAIRMAN: Going from there to one would suggest on account of that is said that you don't have a shortage of nurses, is that correct?

MR. CHAIRMAN: No, I have a very large shortage.

MR. CHAIRMAN: I am afraid, interest is in that field.

THE CHAIRMAN: Mr. Chairman.



Chittick 9272

ladies and Reverend Sister, just for one moment would you please bring me up to date. I think your progress is such you have left me behind. Would you bring me up to date on this question of the various kinds of nurses that are recognized today. You are speaking in terms of or on behalf of university degree nurses.

DR. CHITTICK: Well, yes, sir. We are speaking on behalf of those nurses who are prepared within the university and those nurses who graduated on diploma courses in hospitals and later came to university and obtained a degree, and of the qualified high school graduate who enters the university program and graduates with a degree.

COMMISSIONER BALTZAN: In your universities then, do you have a degree nurse and the nurse who goes on obtain a Bachelor and do you have in the universities a nurse who goes to obtain a diploma in public nursing, paediatrics or psychiatry and these must be registered.

DR. CHITTICK: Yes, these are post-graduates or beyond the post basic program in nursing, yes.

COMMISSIONER BALTZAN: I want to say, as I understand in your brief there should be greater encouragement for the registered nurses to go into the course in the university and obtain these specialties and you also want to see nurses continue or take up their courses by way of university schools.

DR. CHITTICK: That is right. I would like to just emphasize one further thing: We feel that







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far too many graduate nurses come to university and take one year and obtain a diploma. This isn't sufficient preparation for teaching, nor is it sufficient preparation for public health nursing. The diploma is generally one year within a university. This doesn't have any very great breadth of education. Some of the universities feel so keenly about this that they have refused now to give a diploma in teaching. The University of British Columbia is one. They feel it is not adequate preparation for teaching. This has gone on because bursaries have been given by Dominion, Provincial grants or Provincial grants for one year at university, but it has been very difficult to get a bursary to continue on into the second year. In fact, most Departments of Health have discouraged nurses from taking more than one year by saying, we can't give you a bursary to take more than one year, this is sufficient. There has been the attitude this is sufficient preparation.

COMMISSIONER BALTZAN: You would want at least two years?

DR. CHITTICK: Two to three years. We think a baccalaureate degree is essential, that the amount of work that is equivalent to acquiring a baccalaureate degree is essential because in acquiring such a degree she gets breadth of education in the humanities, liberal arts and social science which prepares her to face new situations and to use this knowledge in developing a better program wherever she is.

COMMISSIONER BALTZAN: Is it your ultimate objective, and I put that in the form of a question,





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that you might look towards the time when all nurses will be baccalaureate nurses?

DR. CHITTICK: We would feel, and I think this idea was brought out and stated by the Ontario group who appeared before us, I think we have to face the question of professional nurses, this should be the minimum requirement of professional nurses as it is the minimum requirement in all other professions. I think somebody asked earlier here, perhaps it was Dr. Van Wart, are we calling other people unprofessional. I don't think this is the question at all, nor are we lowering the status of other people, but in the whole advancement of education and our society I think we have the right to expect professional nurses will be prepared in the university and will have, at least, a baccalaureate degree.

COMMISSIONER BALTZAN: I don't doubt, Dr. Chittick, it is a most admirable objective. I wonder if there is a lesson to be learned from the trends in the medical profession that with increased requirements and a tendency towards a great deal of specialization that there has been developing an element of reduction in the numbers of the general practitioners. This has been a concern, as you probably well know, and it seems if I follow you, and if my thinking is right, that you are probably heading in that direction, and conversely from your upward trend, using the situation of the medical profession, there has been a reverse course in that there is more emphasis being placed on retaining the position of the general practitioner in the life work of the





and you must look towards the time when all nurses

will be bachelors and as

M. Chittick: We would feel, and I

think this idea was brought out and stated by the Ontario  
group who appeared before us, I think we have to face the

question of professional nurses, that should be the

minimum requirement of professional nurses as it is the

minimum requirement in all other professions. I think

somebody asked earlier here, perhaps it was Dr. Van Wert,

are we calling other people unprofessional, I don't

think this is the question at all, nor are we lowering

the status of other people, but in the whole advancement

of education and our society I think we have the right to

expect professional nurses will be prepared in the

university and will have, at least, a bachelors

degree.

COMMISSIONER BARTON: I don't doubt,

Dr. Chittick, it is a most admirable objective. I wonder

if there is a lesson to be learned from the trends in

the medical profession that with increased requirements

and a tendency towards a great deal of specialization

that there has been increasing element of isolation

in the minds of the people in professions. This has

been a concern, as you probably well know, and it seems

if I follow you, and it is thinking is right, that you

are probably heading in that direction, and certainly

from your present trend, using the illustration of the medical

profession, there has been a real isolation in that there

is more emphasis being put on retaining the position

of the general practitioner in the field of the



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profession as against intensifying the course and making  
it more elaborate and increasing the numbers of  
specialists.

profession as against increasing the number of  
it more elaborate and increasing the number of  
specialists.



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DR. CHITTICK: No sir. I cannot agree that it is similar to the medical profession. I think the medical profession lends itself to this tremendous amount of knowledge; various specialties, but the tendency in university Schools of Nursing is to look at clinical practice. We are not prepared - the university school is not designed to prepare administrators and teachers only, but it is designed to prepare good practitioners of nursing and in many of the advanced programs, in all of the university schools across Canada, emphasis is placed on how can we best serve the patient? How can we nurse the patient and in preparing teachers we take them right to the bedside. We teach then bedside manner no matter if they have been a graduate nurse or not. We try to show then what is involved in good nursing and with advanced education, the emphasis is put on good clinical practice.

How can we nurse a patient well? How can we improve direct nursing care? No matter what course they are on, whether administrative, and I think this is a false impression that universities are interested in preparing the top echelon or the top groups and this is not true. We are trying to prepare people to see that the patient gets good nursing care.

COMMISSIONER BALTZAN: You are trying to make nursing education more sound?

DR. CHITTICK: That is right; we are.

COMMISSIONER BALTZAN: Following this trend actually the three-year course of nursing will eventually give way to a five-year course?







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DR. CHITTICK: No. I think this is - what will happen will be that one group will be prepared, as Mrs. Duncanson said in the brief this morning, will be prepared in the university and then another group will be prepared in some type of educational institution outside the university and they will still be the largest group and it probably would be less than three years. It has been suggested two years.

COMMISSIONER BALTZAN: This will not be the Baccalaureate?

DR. CHITTICK: No.

COMMISSIONER BALTZAN: Some other school away from the present type of hospital training school?

DR. CHITTICK: Right. I think that it's pretty well agreed that nursing education should be within the general framework of education of the province. Now, what this means in aids it's very hard to state yet but in Ontario it has been suggested that the Department of Education be given a division and the expert Nursing Committee, World Health Organization has gone into this.

It suggests the Department of Education. Now, whether it's the Department of Education or a division of the Department of Education should take on this - have this job to do and they may delegate it.

As you know, in the various briefs being prepared on education there seems to be a great need across the country for some type of school between the high school and the university. Whether it's junior college or whether it's advanced technical school, some





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type of school beyond the high school, post-high school but not necessarily university and this would seem to be quite an ideal place later for the education of nurses, to be centred there and I think it is up to the Department of Education that have nursing needs - first of all, educational grants which have to be within the general framework of the education of the province.

COMMISSIONER BALTZAN: You have answered my question very well. I know that you have started on a new subject and I think that will take separate consideration, the question of separation of the training schools and hospitals and we will leave that for some other time.

COMMISSIONER VAN WART: Just one question I wish to ask. How many university Schools of Nursing are there in Canada?

DR. CHITTICK: There are 14 university schools who have Schools of Nursing. Now these are not all what we would call university schools in the pattern of education in university schools. There are many university Schools of Nursing granting degrees in which they take part of their education within the university, part in a hospital school.

COMMISSIONER FIRESTONE: Dr. Chittick, in Recommendation 2 on page 1, you say that you recommend that the present obligations required by bursary recipients be made less restrictive. What are some of those restrictions that you would like to see either removed or lessened?

DR. CHITTICK: These restrictions are







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4 set up provincially and they vary tremendously from one  
5 province to another. In one province, for instance,  
6 three months of service is required for every month of  
7 education so that if a student comes to university for  
8 one year, she is required to return to the province for  
9 three years. If she comes for two years, it's six years  
10 and this is a long time. A very severe restriction so  
11 that students hesitate, are very reluctant to apply for  
12 a bursary because it's getting into indentured labour for  
13 a long time.

14 The next is that theoretically these  
15 bursaries are set up for hospital and public health  
16 agencies and it's up to the public health agency or the  
17 hospital to select the candidate. Now, that is a limita-  
18 tion because they may not have a good candidate on their  
19 staff or they may have somebody who is not willing to  
20 accept such a bursary and yet there are plenty of people  
21 who are applying to universities for bursaries where  
22 universities can check their qualifications and see the  
23 kind of people they are but they have no authority to  
24 give this person a bursary.

25 Then, also, the bursaries, of course,  
26 have not changed in amount very much over the many years  
27 since they were set up and they are very small.

28 COMMISSIONER FIRESTONE: Does the  
29 Federal Government offer bursaries to schools?

30 DR. CHITTICK: Not directly. They offer  
them, well, to their own staff. To those nurses who are  
engaged in D.V.A. hospitals, Army and Navy, but other  
bursaries come through professional training grants from





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the Federal Government to the province.

COMMISSIONER FIRESTONE: Would your recommendation be that the Federal Government in making this grant for the province attach a rider which would require the province to either remove such restrictions or lessen them?

DR. CHITTICK: Yes, I think that first of all that it's very difficult, I think, to administer these by - for instance, by the Department of Health in each province. It would seem this would be much better administered by some sort of educational authority. Now, in the United States the Federal Government gives their grant directly to the universities. They have set aside large sums of money for advance preparation of nurses and these grants are given to the universities. Now, I don't know whether that is possible in our set-up, legally, under the Dominion-provincial relationship.

COMMISSIONER McCUTCHEON: Some universities will accept them.

DR. CHITTICK: Well, yes. Then there is, of course, the Canada Council and Research Council and there might be others who could accept these grants as university grants are accepted now, from the Federal Government.

COMMISSIONER FIRESTONE: Just assume that the constitutional question which you raised can be resolved either through Canada Council or some other medium. Would you be in favour of bursaries being made available and scholarships and fellowships by the Federal





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Government, it is the fact that

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Government to the nursing profession directly?

DR. CHITTICK: Yes.

COMMISSIONER FIRESTONE: Would you wish that these scholarships, bursaries, be made available to universities or to the nurses directly?

DR. CHITTICK: Like the Canadian Nurses' Association?

COMMISSIONER FIRESTONE: Well, no; what I am asking ---

DR. CHITTICK: To individuals?

COMMISSIONER FIRESTONE: --- is that there would be certain scholarships available to people, and that nurses that are interested in obtaining such scholarships would apply. For example, if you are a social worker you can apply to Canada Council for a scholarship and if you are eligible, you may be awarded such a scholarship. Would you make this scholarship available to each university or would you make it available to the applicant directly? What sort of system would you recommend? Or both?

DR. CHITTICK: Well, I think both. I would like to ask Miss Weir to speak to that.

MISS WEIR: I think this is a problem which does not present itself easily unless you are in the university field. The undergraduate student increasingly is better off. For instance, the girl who comes in from high school can get quite a lot of help if she is a particularly good student but the graduate nurse coming to university is cut off from almost all available financial aid because of various restrictions because she





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wasn't in an educational institution that is recognized by the university previously. She cannot have many of the grants which would be available, and, of course, there are the restrictions in the Canada Council that she cannot belong to a profession and have a grant, and work. The problem is very acute for the graduate nurse who is not recognized as having come from a regular educational institution. It's very severe and I would feel that the money should be made available in the way - having been a recipient of the Department of Veterans' Affairs grants I feel that there is no doubt that I had great loyalty to this country. I had no intention of staying out of the country, although I took my education, I came back with the freedom to move wherever I was needed in Canada.

I think it's the provincial legislation that limits many of our nursing leaders in this country. These restrictions are very severe.

COMMISSIONER FIRESTONE: Would your suggestion be that such scholarship plans for nurses that the Federal Government may offer would cover both undergraduates as well as graduate nurses?

REV. SISTER LEFEBVRE: Yes. I think it should cover both the nurse who has been trained in the hospital or other schools of nursing.

COMMISSIONER FIRESTONE: And if such a federal plan were developed would you feel that it should have no limitation as to residence requirement in Canada, including provinces of the choosing of the nurses, or should they have requirements for a year or two to stay in







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Canada after graduation or three years, whatever the case may be?

DR. CHITTICK: I think they have an obligation to stay in Canada but I think that the restrictions as they are now - you must go back to a particular institution in a particular city, in a particular province.

COMMISSIONER FIRESTONE: My question refers to a federal plan which would offer no restriction whatsoever within Canada. My question to you is whether it would be reasonable that such an award of the federal fellowship would have the contingency that any nurse would stay one year or two years or three years, whatever the case may be, in Canada.

Would you support such a recommendation?

DR. CHITTICK: Yes, I would.

COMMISSIONER VAN WART: Is it not true that many of these nurses who get the bursaries from a certain community get it by virtue of a need for that service in that community?

DR. CHITTICK: Yes, that is true.

COMMISSIONER VAN WART: If no restrictions were put on wouldn't that defeat the purpose of the community getting the service of the nurse, if it was an undesirable community?

DR. CHITTICK: They only get the service for a very limited time, if the person doesn't want to stay there. They may get that person to come back for a year. I think there would be more people applying and there would be a larger pool from which everybody could





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draw.

COMMISSIONER VAN WART: Wouldn't there be a tendency for the nurse not to go into some undesirable place that needs her service?

DR. CHITTICK: I think that is true no matter what field you are working in, if there is such a thing as an undesirable place.

COMMISSIONER VAN WART: Is not the restriction on the bursary just a means of getting the nurse into that undesirable place?

DR. CHITTICK: If it is I think it's a very poor policy because the girl is coming back to that place under protest, if she doesn't want to go there. She is going to stay the least time she can.

COMMISSIONER VAN WART: How is that community to get the service of the nurse then if this mechanism is not working?

DR. CHITTICK: Until they make it attractive enough.

THE CHAIRMAN: Make it more attractive in terms of living arrangements, in terms of the job to be done.

DR. CHITTICK: I don't think there are any places where you couldn't attract somebody. In the north, the Department of Indian Affairs is able to get people up into remote areas and they like it.







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COMMISSIONER FIRESTONE: I take it, Dr. Chittick, that we were really talking about a federal plan where there would be no restrictions within Canada because the Federal Government cannot tell the provinces how they formulate their own plans. We might have both types of bursaries and if we get more nurses as a result of using a plan with less restrictions then the nursing profession as a whole and the Canadian public as a whole will benefit. Is that your view?

DR. CHITTICK: Right, I agree with that.

COMMISSIONER FIRESTONE: Then, paragraph 3 of your recommendations on page 1, in which you call for greater leadership from the Federal Government and you say:

"This leadership should consider a much higher range of salaries for senior positions and generous bursaries for university preparation."

I take it when you speak of generous bursaries for university preparation, again, you are referring to undergraduate and graduate?

DR. CHITTICK: Right.

COMMISSIONER FIRESTONE: How about the system of pay leave of absence to undertake such graduate studies or undergraduate work on half salary? Would this be part of the leadership which you are recommending or would this be one other method of achieving your objective?

DR. CHITTICK: Right, sir. I think that is one that should be promoted much more than it is now. It is true that the armed services are giving a leave of





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absence to a very limited number. We get applications from the nurses in the armed forces but the number is so small, they say they have to wait a year or two for a bursary and there is one away now and they cannot let another away on leave of absence.

COMMISSIONER FIRESTONE: Do the armed services pay full salary or half salary? I know that in the Civil Service, not the armed forces, but in the Civil Service, they pay half salary but, again, on a select and individual basis.

DR. CHITTICK: Well, we have had students on full salary but I am not sure it is general throughout the country.

COMMISSIONER FIRESTONE: Would your recommendation be that there should be more of these leave of absence arrangements granted as far as the Federal Government is concerned and if so should it be on half or full salary?

DR. CHITTICK: Miss Allen would speak to that.

MISS ALLEN: I imagine it would depend on the size of the bursary. The salary is fairly low so half the salary is not very much and if it is a small bursary it would be difficult.

COMMISSIONER FIRESTONE: So your feeling would be that the arrangement should be tied to the financial requirements of the nurse to see her through her training period at the university and if her salary is small she should be given a full salary but at least it should be enough to cover her living expenses plus her







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school fees?

DR. CHITTICK: Right.

COMMISSIONER FIRESTONE: And you so  
recommend?

DR. CHITTICK: Right.

COMMISSIONER GIRARD: Dr. Chittick, on  
page 9 under paragraph 22, you say:

"At present there are over 20,000  
students in hospital schools but  
only 900 students in basic nursing  
programs within the university.  
This means that only 5% of student  
nurses are enrolled in university  
programs. The Canadian Conference  
of University Schools of Nursing  
believes that this number could be  
increased by a larger number of  
scholarships and bursaries and by  
selected hospital schools in univer-  
sity centres abdicating the field of  
nursing education and making their  
facilities available to university  
schools."

I have two questions on that and the  
first one is, on what basis would this selection be made?

DR. CHITTICK: The increased number?

COMMISSIONER GIRARD: No, you say "by  
selected hospital schools in university centres abdicating  
the field of nursing education"; what basis would you use

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DR. CHITTICK: There are across the country university hospitals that are closely associated with the universities, particularly with the medical schools, but these university hospitals still carry diploma courses. Now, there are universities associated with medical schools known as university teaching hospitals and it would seem to me that these hospitals would lend themselves to the development of undergraduate programs, university programs in nursing. They are in teaching centres, the quality of medical care is high because they are associated with the medical school and they come within the framework of the university.

COMMISSIONER GIRARD: This would be to make more facilities available?

DR. CHITTICK: Clinical facilities and classroom facilities and so on.

COMMISSIONER GIRARD: This, what I call the appendix, this paper prepared by the McGill Faculty of Nursing on Better Prepared Teachers for Schools of Nursing; on page 6 it shows there are 318 basic degree program vacancies, 318 students could be accommodated presently in basic degree programs so that we have not used up all our facilities so far, we still have some before doing this which I think is a good thing. We do have 318 vacancies.

DR. CHITTICK: That is right.

COMMISSIONER GIRARD: For basic degree programs?

DR. CHITTICK: This is true, we have not attracted them and until there are students available,







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as Mrs. Duncanson pointed out, we have many people qualified for entrance into university who are in the diploma hospitals.

COMMISSIONER GIRARD: So we could do something better in selection of nurses?

DR. CHITTICK: Oh, yes.

COMMISSIONER GIRARD: We have facilities for these 318 additional ones; we have room for 167 persons in graduate nurse programs according to this?

DR. CHITTICK: Right.

COMMISSIONER GIRARD: On page 10, paragraph 26:

"That Departments of Health encourage continuing education of public health nurses within the university, and that they recognize that the preparation for public health nursing is at least a Baccalaureate degree. One survey showed that only 11.5% of public health nurses had a degree in nursing."

Could we foresee in public health nursing, using other categories of nurses also, for instance, nursing assistants?

DR. CHITTICK: Yes, I think that is true and I think it has been demonstrated by some of our public health agencies that they can be well used.

COMMISSIONER GIRARD: Why is this not done more frequently, in your opinion? Among the briefs we have had going across Canada I think there were only one or two organizations using very few and this could





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free some people; these organizations that are short of staff could free some graduate nurses. What stands in the way of using more?

DR. CHITTICK: I think the problem of using nursing assistants is largely in the agencies who give home care. Many of our organizations in public health such as the Canada Health League or the official health agencies do not give home care and it is a little more difficult to use assistants because of the nature of the work because it is largely counselling and advising, counselling teachers in a school program or counselling parents and working with parents and I think it is more difficult to use an assistant.

COMMISSIONER GIRARD: Can you see also using nurses without degrees in well-baby clinics in public health nursing?

DR. CHITTICK: Yes, indeed. I think we could have nurses, use all categories of nurses really, but we are in need of them, we desperately need a much better planning in public health. I think there is a tendency for public health to be a routine, certain procedures to be done, certain jobs to be done and we need to lift public health into public health and hospitals together to see the whole health services of the needy and co-ordinate them. This is very difficult to do with the number of people we have prepared or the kind of preparation we have had in public health nursing.

May I just add one rider; as home care programs develop I think we will need many more. We may use assistants because I think the public health nurse is







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the only person to supervise home care.

COMMISSIONER GIRARD: I have a number of questions here that have already been answered. Again, consulting this paper, on page 12, you are speaking of entrance requirements and length of program, Canadian University Schools of Nursing, 1960. You have this with you?

DR. CHITTICK: Yes.

COMMISSIONER GIRARD: Where students enter with senior matric what is the reason that some of the university schools are taking five years and some are not with students entering with the same basic preparation, Grade 13 or senior matric?

MISS WEIR: May I speak to that? I represent one of the universities which has a five-year program. As you are well aware, the pattern is what we call a one-three-one pattern and this means the student is a year on the campus, three years in a hospital centre and then one year back at the university in which they specialize in public health or teaching. It is the commonest pattern still but the universities offering this pattern are very eager to get out of it.

Incidentally, there is a correction to be made; our university is now asking 65% and this is creating one of our most serious problems, I would say, in the university field. As we increase the university entrance standard, and I feel students should not be admitted to the campus with less admission standard than the lowest standard for an arts degree, as we raise this standard we are getting increasing comments from the





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4 students that they find their experience in the hospital  
5 or diploma school less than stimulating. There is a  
6 great cry from them that they want to be associated with  
7 the university teachers more and more. This problem of  
8 offering this type of program is one of finance. The  
9 budget which you would have to present to the university  
10 to offer this kind of program is considerably higher than  
11 is necessary, as you may well reason, for the one-three-  
12 one type of program.

13 I think that the universities are going  
14 to have to make a plea for these additional funds and  
15 I think as our standard rises the universities offering  
16 this kind of program are going to find that students  
17 are transferring from us if they do not get more depth of  
18 study, more opportunity for critical thinking than the  
19 university program.

20 The problem of well-trained staff for  
21 handling this kind of applicant too is a very real  
22 problem. The Canadian Conference of University Schools  
23 have done quite a lot over the past six years to assist  
24 one another in interpreting what the universities should  
25 be offering in the way of a university course. I think  
26 this is one of the things our Association is doing,  
27 trying to interpret to the universities that you must,  
28 as soon as possible, stop this kind of program. The  
29 university does not grant a degree for anything else for  
30 two-thirds of the work.

COMMISSIONER GIRARD: You feel this  
type of program should be gradually disappearing?

MISS WEIR: Oh, yes.





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students that they find their experience in the hospital  
on doing a school less than satisfying. They want  
to get away from them that they want to do something with  
the university that has more and more. This project of  
offering this type of one year is out of finance. The  
budget which you would have to present to the university  
to offer this kind of program is considerably higher than  
is necessary, as you may well imagine, for the one-third  
the cost of program.

I think that a university is a good  
to have to make a place for these additional funds and  
I think as our standards and the universities offering  
this kind of program are going to find that students  
are transferring because they do not get more down to  
study, more opportunity for critical thinking than the  
university program.

The problem of self-trained staff for  
handling this kind of application is a very real  
problem. The Canadian Institute of Medicine in its  
have done quite a lot over the past six years to make  
the another in interesting ways the university should  
be offering in the way of a university course. I think  
this is one of the things our Association is doing,  
trying to interest in the university as they want,  
as soon as possible, and this kind of program. The  
university does not want a course in anything else for  
teaching of the work.

Now I think that the university is in a position

to do this kind of work.



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COMMISSIONER GIRARD: And it is taking the student five years where if she went in directly it would be four years?

MISS WEIR: I think the length of the course should be up to the university, it is up to them.

COMMISSIONER GIRARD: But it is being done now with an integrated program for four years with senior matric.

MISS WEIR: And with some it is four years after junior matric and I think it must be left to the university.

COMMISSIONER GIRARD: Well, I was talking about senior matric, we were considering that.





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4 COMMISSIONER BALTZAN: During your  
5 present aim at preaching learning for the nurses  
6 generally, there is currently a difficulty and stalemate  
7 with relation to some nurses in this transitional  
8 period as for example a nurse well-qualified, experienced,  
9 and known to be suitable for a given position, will  
10 be told: "You cannot have that position, that position  
11 must be filled by a university-trained nurse, or if you  
12 fill that position you cannot receive the amount paid  
13 for that position unless you are a university-trained  
14 nurse".

15 Is there something that can be done  
16 for these very competent, able people, that can suit  
17 these positions, and fill these positions during this  
18 transitional period, because it is a drawback for  
19 very able nurses, who could do a good job in their  
20 particular posts?

21 DR. CHITTICK: I think these individuals  
22 would be certainly considered, and there would be no  
23 reason for eliminating a person from a position where  
24 she is doing a very satisfactory job. This is true  
25 in the teaching profession, where they made the  
26 stipulation that teachers be university graduates, and  
27 there are many who are not, and there is no suggestion  
28 that you oust these high school teachers, and I don't  
29 think this would be any more true in the nursing  
30 profession.

31 COMMISSIONER BALTZAN: I would agree  
32 with you very heartily, except that I know that that is  
33 the case in many instances.







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DR. CHITTICK: Well, that is a case of very poor management, or there is something in relation to poor judgment.

MISS WEIR: I think there are various ways in which you can get university preparation, and when you are in a university you meet a lot of people who try to use this excuse, that the university are trying to keep them out, and many Canadian universities offer extra, extramural courses, and I don't think there is any nurse of competence who has ever been kept out of a university program if she wanted to make the effort to fulfil her necessary qualifications.

COMMISSIONER BALTZAN: That was not my point.

MISS WEIR: I am sorry, I misunderstood you.

COMMISSIONER GIRARD: On page 5 of this interesting paper, and in the middle of the paragraph:

"In many basic university programs  
"students elect to major in either  
"teaching or public health nursing in  
"their final year."

You are talking about the basic degree program, and I am under the impression, correct me if I am wrong, that you didn't elect to specialize in the basic degree program?

DR. CHIITTICK: This is true in those that are integrated programs, that is, those programs that are totally under the jurisdiction of the university. The student is prepared for first level positions in hospitals and public health, but there is the tendency





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4 in those one-year, two-year, and three-year programs  
5 that in their final year they are trained either as  
6 teachers or public health nurses.

7 COMMISSIONER GIRARD: Is the intent,  
8 or the philosophy of the Conference of the university  
9 schools that this should disappear with the one, two  
10 and three?

11 DR. CHITTICK: Yes, I think this would  
12 disappear.

13 COMMISSIONER GIRARD: That you do  
14 not specialize in a basic degree?

15 DR. CHITTICK: Yes.

16 COMMISSIONER GIRARD: Thank you very  
17 much. Some of the questions I had have been answered  
18 previously.

19 THE CHAIRMAN: Thank you very much,  
20 Dr. Chittick, Sister Lefebvre and your associates. This brief  
21 and the discussion will be taken into consideration  
22 as we come to consider the pages of our report that  
23 deal with nursing, nursing education and nursing  
24 utilization. As you know, the Commission has commissioned  
25 studies in various phases of the nursing field, and these  
26 briefs will naturally be very valuable to our research  
27 staff, and in connection with those studies as well,  
28 so thank you very much.

29 DR. CHITTICK: I would like to thank  
30 you, sir, on behalf of the Canadian Conference of  
University Schools, for the privilege of presenting this  
brief this morning.

THE CHAIRMAN: Dr. Jobin, you have a







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3 submission?

4 DR. JOBIN: As previously advised  
5 I have a submission of the Registered Nurses' Association  
6 of British Columbia, who are not here to present their  
7 brief, and in this case I would recommend that the  
8 Preamble and the Summary and Recommendations of this  
9 submission be made part of today's record, and that  
10 this submission be known as Exhibit number 249.

11 THE CHAIRMAN: This submission, which  
12 has come in by mail and with no arrangements for any  
13 verbal presentation, will be received as Exhibit number  
14 249, and the preamble and recommendations will become  
15 part of today's record, and the Registered Nurses'  
16 Association of British Columbia will be advised  
17 accordingly.

18 ---EXHIBIT NO. 249: Submission of the  
19 Registered Nurses'  
20 Association of British  
21 Columbia.





SUBMISSION OF  
REGISTERED NURSES' ASSOCIATION OF  
BRITISH COLUMBIA

PREAMBLE:

Over the past weeks during which the Royal Commission on Health Services has been holding public hearings, the Registered Nurses' Association of British Columbia has read with interest and enlightenment the expressed philosophies and recommendations contained in the submissions of various agencies, associations and individuals concerned in serving the health needs of the people of Canada. The Registered Nurses' Association of British Columbia appreciates very much this opportunity of presenting in its turn, for the enlightenment of the Royal Commission and other interested agencies and associations, some facts about nursing that are pertinent to the provision of health services in British Columbia, and some recommendations that an examination of those facts has led us to propose.

In pointing out certain shortcomings in the nursing care the public is receiving, the nursing profession itself must accept responsibility for taking some of the corrective measures necessary - for some of the shortcomings are a result of its own sins of omission. However, due to the manner in which our society renders us dependent one upon another, collectively as well as individually, a good many of the shortcomings can be corrected only by joint action







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4 with other professions and organizations, and with the  
5 understanding and support not only of its elected  
6 representatives but of the public generally.

7 The contents of our brief have been  
8 reviewed and endorsed by the Executive Committee of  
9 our Association. It has not been possible to clear  
10 with the 8,724 membership all the points included.

11 We regret that circumstances prevent  
12 our sending representatives to meet with the Royal  
13 Commission to answer any questions arising from our  
14 brief. We are confident, however, that our submission  
15 will receive the same careful consideration as though  
16 it had been presented in person, and that, should any  
17 points require clarification, we will be called upon  
18 to elucidate.

19  
20 SUMMARY AND RECOMMENDATIONS:

21 We believe that our society regards  
22 health as a basic human right, and in Canada all our  
23 people should have access to comprehensive health  
24 services, the quantity and quality of which are determined  
25 by need alone. Without adequate nursing services  
26 effective health services are not possible, for nursing  
27 provides a vital link between the rapidly multiplying  
28 benefits of medical science and their utilization by  
29 the public. This is the reason for our existence as a  
30 profession, and it is to our mutual advantage that the  
quality of service should be as good as we can make it.

In accordance with paragraphs (a) and  
(d) of the Order in Council P.C. 1961-883, we have in-  
cluded in our submission some information concerning





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4 existing methods of providing nursing service, numbers  
5 of nurses available, estimated future requirements and  
6 nursing education facilities. In accordance with  
7 paragraphs (b) and (d) we have made recommendations  
8 for improving nursing service and facilities for  
9 preparing nurses.

10 Rapid technical and social change is  
11 a characteristic of our times. The ever increasing store  
12 of available scientific knowledge has resulted in  
13 increasing specialization, and a greater variety in  
14 the kinds of health workers taking part in health  
15 services and making teamwork essential. The role of  
16 the nurse is changing and will continue to change. If  
17 nursing is to keep pace with the needs of society,  
18 research methods must be applied in nursing to a much  
19 greater degree.

20 Although the supply of nurses for  
21 certain functional and clinical areas is inadequate, our  
22 over-all supply is sufficient to meet the demand except  
23 in the summer months when most vacations are taken and  
24 most resignations occur. Rather than a need for more  
25 nurses, our investigations indicate a need for better  
26 utilization of available nursing personnel. Better  
27 utilization is closely linked with efficient nursing  
28 administration and supervision. Unfortunately, qualified  
29 nursing administrators, consultants and supervisors  
30 are in very short supply, and the services of those  
we have are not being used as effectively in the planning  
and implementation of health services as they might be.  
We suggest the establishment of Divisions of Nursing at







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4 Federal and Provincial levels as the first step toward  
5 more effective utilization of nursing personnel.

6 The severe shortage of nurses for posts  
7 above the general staff level in hospitals is perhaps  
8 the greatest barrier to better utilization. There is  
9 little incentive for nurses to accept more senior posts.  
10 Salary differentials in most agencies do not begin to  
11 compensate for the added responsibility involved, not  
12 to mention the cost of the added preparation that should  
13 be a requirement for senior positions. Graduation from a  
14 hospital diploma program does not prepare a nurse for  
15 positions above the general staff level in hospitals,  
16 nor do inservice programs provide an adequate substitute  
17 for well planned university programs in nursing  
18 administration or supervision. If the shortage of  
19 qualified senior nursing personnel is to be overcome,  
20 more nurses must be encouraged to enter basic degree  
21 programs, salary policies must be such as to make advance-  
22 ment more attractive, and opportunities and facilities  
23 for post-basic and post-baccalaureate preparation must  
24 be provided.

25 The practice of using nurses for  
26 functions other than nursing is one factor that helps  
27 create an apparent nursing shortage. Rapid turnover of  
28 nurses, particularly in our hospital services is another.  
29 Inservice education is an effective method of promoting  
30 a high level of performance, and when this includes  
provision for a thorough orientation of new personnel,  
the ill effects of staff turnover can be mitigated to a  
large degree.





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4 Because of a shortage of male nurses  
5 and male practical nurses, certain nursing procedures  
6 for male patients are carried out by male attendants  
7 and orderlies. In many instances the inservice prepara-  
8 tion and the supervision they receive is limited. Since  
9 orderlies are paid higher salaries than practical  
10 nurses, and almost as much as registered nurses, there  
11 is no financial incentive to encourage young men to  
12 become nurses. Urological services, rehabilitation and  
13 psychiatric units are examples of services in which  
14 male nurses could make an especially useful contribution  
15 to patient care.

16 If the Commission agrees with our  
17 submission that need alone should determine the quality  
18 and quantity of health care available to our people,  
19 steps should be taken to improve the quality and  
20 quantity of care available to the mentally ill and  
21 mentally defective. We are particularly concerned with  
22 the provision of better nursing services, but recommenda-  
23 tions aimed at removing other inequities are also  
24 included.

25 The value of home care programs has  
26 been proved, and with the expansion of home care programs  
27 has come a growing realization that families are not  
28 always able to utilize existing health facilities if  
29 housekeeping services are not also available. Compre-  
30 hensive health services should make provision for the  
inclusion of homemaker services in home care programs.  
Facilities for training homemakers are also needed.

Nothing can have a greater influence







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4 upon the quality of nursing service than the quality  
5 of nursing education. When the pilot project for the  
6 Evaluation of Schools of Nursing in Canada reported  
7 that only 16% of the schools surveyed were of a quality  
8 considered desirable, the Canadian Nurses' Association  
9 undertook to make a re-examination and study of the  
10 whole field of nursing education. We are expecting the  
11 findings of this study to be of great value in future  
12 plans.

13 The hospital schools are producing  
14 about 95% of our nursing practitioners. We believe  
15 that our six hospital schools in British Columbia have  
16 been doing a creditable job. However, we appreciate  
17 the dilemma in which the administration of a teaching  
18 hospital is placed. Nursing can no longer be taught by  
19 apprenticeship methods; yet the students are part of  
20 the hospital service personnel, and when additional  
21 students are enrolled the complement of other nursing  
22 personnel for which the hospital can budget is reduced.  
23 We believe that the method of financing nursing  
24 education partly through hospital operating costs and  
25 partly through service rendered by students is no  
26 longer an adequate or desirable one. New patterns in  
27 financing and administering schools of nursing are  
28 advisable and may bring increased need for financial  
29 assistance to students.

30 The Mental Health Services Branch  
of the B. C. Department of Health and Hospital  
Insurance is conducting a research project in nursing  
education. A two-year program is proposed to prepare





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4 students for first level nursing positions in general and  
5 psychiatric hospitals. Public health aspects of  
6 nursing will be integrated throughout, and emphasis will  
7 be placed upon learning by principle. It is hoped  
8 if financial support is found that the University of  
9 B.C. will agree to conduct the program on a research  
10 basis. Should the plan materialize, graduates of this  
11 program will help to relieve the shortage of nurses  
12 caring for the mentally ill and mentally defective. We  
13 are hoping, too, that a fair proportion of male students  
14 may be interested in entering this kind of program.

15 To provide a nucleus from which can  
16 be drawn instructors for our schools, head nurses, and  
17 nurses qualified to enter post-baccalaureate programs  
18 to prepare for leadership positions, it is imperative  
19 that many more candidates for nurse training should  
20 enter the basic degree program. To make this possible  
21 the facilities now available at the University of B.C.  
22 School of Nursing will have to be greatly expanded.  
23 We believe that by 1985 approximately 20% of students  
24 entering nursing should be entering the university  
25 program. In addition to this, facilities for post-basic  
26 degree preparation must be maintained. Post-basic  
27 diploma courses should be continued until there are  
28 sufficient numbers graduating from degree programs to  
29 meet service needs for nurses with post-basic preparation.

30 We look to our universities to give  
leadership in a number of areas, of which nursing research  
is one and continuing education for nurses another.  
With the constant increase in the fund of scientific







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4 knowledge available, graduation from a basic program can  
5 only be the commencement of a lifetime of continued  
6 learning. Other members of the health team are being  
7 prepared in the universities, and interdisciplinary  
8 sharing of suitable educational experiences could help  
9 to build the foundation of mutual understanding and  
respect upon which effective teamwork rests.

10 RECOMMENDATION:

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12 I That a division of nursing be established  
13 within the Department of National Health and Welfare,  
14 headed by an appropriately qualified chief nurse who  
15 could speak for nursing at the policy making levels, and  
16 with a staff of appropriately qualified nursing  
consultants for special fields of nursing.

17 II That British Columbia Hospital Insurance  
18 Service take a leadership role in strengthening and  
19 improving the quality of nursing in B. C. hospitals by  
20 establishing within its framework a nursing consultation  
21 division. This division should be headed by a senior  
22 consultant who could speak for nursing at the policy  
23 making levels, and should have a staff of nurses  
24 appropriately qualified to provide consultant services  
25 in various specialty areas. The nursing consultation  
division would include among its functions:

- 26 a) Assisting hospitals in establishing and  
27 maintaining sound and efficient standards of  
28 care and of administrative practices in those  
29 phases of operation concerned with nursing  
30 service;





- b) From first-hand knowledge of the hospitals in question, advising the hospital finance division on costs relating to nursing service in those hospitals;
- c) Assisting the hospital construction and planning division in the design and approval of hospital plans through interpretation of the needs of patients and assessment of the adequacy and convenience of nursing service facilities;
- d) Conducting continuing research in nursing service in conjunction with the research division of BCHIS.
- e) Providing liaison between the RNABC and BCHIS so that plans for expanding hospital services and plans for preparing nursing personnel can be co-ordinated.

III That the Canadian Council on Hospital Accreditation be encouraged to expand its accreditation program to include more challenging goals for nursing service: In order to ensure effective implementation of this aspect of the program, it is suggested that:

- a) Representation on the Council from the Canadian Nurses' Association be sought and
- b) a qualified nursing representative be appointed to assist in survey visits to hospitals and assume responsibility for investigating nursing service aspects.

IV That hospitals be urged to adopt salary policies which provide adequate financial incentive to encourage able nurses to qualify for and move into positions of increased responsibility.





Two, first-hand knowledge of the local situation, including the local division of labor and the division of labor in those hospitals;

3) regarding the hospital construction and planning division in the design and approval of hospital plans through the intervention of the local patient and assessment of the situation and conversion of the existing services into a new service; 4) Conducting construction research in the service in conjunction with the research division of the hospital;

5) Providing liaison between the hospital and the local community, so that plans for hospital services and plans for community services can be coordinated.

6) That the hospital should on occasion be encouraged to expand its service program to include the local community in order to ensure effective implementation of this aspect of the program, it is suggested that

7) Representation on the part of the hospital in the local community should be sought and a qualified person should be appointed to assist in the work of the hospital in the local community, for investigation and research in the service.

8) That the hospital should be encouraged to expand its service program to include the local community in order to ensure effective implementation of this aspect of the program, it is suggested that



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4 V That hospitals be urged to adopt  
5 a policy whereby minimum qualifications for the various  
6 nursing positions are clearly specified and must be met  
7 before a new permanent appointment is made; and that in  
8 the evaluation of nursing service in hospitals the  
9 adequacy of the qualifications of the nursing personnel  
10 in the various administrative and supervisory positions  
11 be considered.

12 VI That hospitals in British Columbia  
13 be urged to apply for federal health grants to sponsor  
14 nursing personnel to attend university courses in  
15 administration and supervision, and that adequate  
16 monies be made available to meet this urgent need.

17 VII That hospitals sponsoring enrolment  
18 of nursing personnel in the Canadian Nurses' Association -  
19 Canadian Hospital Association extension course in nursing  
20 unit administration restrict such sponsorship to nurses  
21 who are unable to qualify for admission to, or whose  
22 home responsibilities prevent them from considering,  
23 a university course.

24 VIII That hospitals be encouraged to grant  
25 leave of absence without loss of seniority to nursing  
26 personnel to attend educational programs designed to  
27 enhance their nursing performance.

28 IX That in addition to the government  
29 grants now available for advanced nursing education  
30 upon application by the service agencies, bursaries  
for advanced study in nursing be made available to  
nurses upon application by the individual nurse, and  
that

V That hospitals be urged to adopt a policy whereby a number of positions for the various nursing positions be clearly specified and made available before a new permanent appointment is made; and that the evaluation of nursing service in hospitals be satisfactory of the qualifications of the nursing personnel in the various administrative and supervisory positions be considered.

VI That hospitals in British Columbia be urged to apply for federal fellow grants to support nursing personnel to attend university courses in administration and supervision, and that adequate facilities be made available to meet this urgent need.

VII That hospitals sponsoring education of nursing personnel in the Canadian Nurses' Association (Canadian Hospital Association extension course in nursing) and administrative position such as assistant to nurse, who are unable to qualify for admission to, or whose home responsibilities prevent them from attending, a university course.

VIII That hospitals be encouraged to grant leave of absence without loss of seniority to nursing personnel to attend educational programs designed to improve their qualifications.

IX That in addition to the foregoing, grants now available for advanced nursing education upon application by the service branches, be made available to nursing personnel for advanced study in nursing be made available to nursing personnel upon application by the individual nurse, and





- a) the service commitment for such bursaries be dischargeable by service in the Province;
- b) the length of the service commitment be proportionate to the amount of money requested;
- c) flexibility in the choice of university be permitted (provided this flexibility of choice is allowed in all the provinces);
- d) provision for assistance to nurses wishing to complete requirements for a Bachelor's degree in nursing be included.

X That the practice of using nurses to "fill in" for other categories of hospital personnel be discouraged.

XI That ward clerks be used more extensively.

XII That hospitals be encouraged to develop inservice education programs and the cost of such programs be recognized as a legitimate budget expense.

XIII That in computing staffing needs for nursing service, adequate provision be made to compensate for the diminished effectiveness factor involved in staff turnover.

XIV That in the evaluation of nursing service the adequacy of the inservice education program (including orientation for new personnel) be considered.

XV That hospitals be urged to adopt a policy whereby the categories, functions, qualifications and salaries of male nursing personnel are equivalent to those of their female counterparts.

XVI That in the evaluation of nursing





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3) the service commitment for each nurse in the province, if practicable, by service in the province;

4) the length of the service commitment be provided to the extent of money resources;

5) flexibility in the choice of university be permitted (provided this flexibility of choice is allowed in all the provinces);

6) provision for assistance to nurses wishing to complete requirements for a Bachelor's degree in nursing be required;

X That the practice of visiting nurses to "fill in" for other categories of hospital personnel be discouraged;

XI That ward clerks be used more extensively;

XII That hospitals be encouraged to develop inservice education programs and the cost of such programs be recognized as a legitimate budget expenditure;

XIII That in computing staffing needs for nursing services, adequate provision be made to compensate for the diminished effectiveness factor involved in staff turnover;

XIV That in the evaluation of nursing services the adequacy of the inservice education program (including orientation for new personnel) be considered;

XV That hospitals be urged to adopt a policy whereby the career, promotion, qualification and salaries of male nursing personnel be equivalent to those of their female counterparts;

XVI That in the evaluation of nursing



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4 service in hospitals the qualifications of the male  
5 personnel participating in the nursing care of patients  
6 be considered.

7 XVII That, as a first step in eliminating  
8 the discrepancy that exists between health services for  
9 the physically and the mentally ill, the salaries of  
10 professional personnel in the provincial mental health  
11 services be such as to enable them to compete with  
12 other agencies employing similar categories of personnel.

13 XVIII That inpatient and outpatient services  
14 for psychiatric patients be developed in the province  
15 as integral parts of community medical facilities as  
16 quickly as possible, and adequate plans for the training  
17 of the necessary personnel (psychiatric teams) be made.

18 XIX That the administration and organiza-  
19 tion of psychiatric and mental hospitals be essentially  
20 the same as those of other hospitals.

21 XX That admission procedure and insurance  
22 coverage for patients entering psychiatric and mental  
23 hospitals be essentially the same as for patients entering  
24 general hospitals.

25 XXI That hospital schools be urged to make  
26 provision for the inclusion of psychiatric nursing  
27 experience in the program of all students.

28 XXII That instruction and experience in the  
29 care of patients with psychiatric disorders be included  
30 in the program of all B.C. schools for practical  
nurses.

XXIII That the Practical Nurses' Act be  
implemented as soon as possible.







XXIV That in planning health services adequate provision be made for the inclusion of comprehensive home care services, including homemaker service.

XXV That programs for the training of homemakers be initiated.

XXVI That nursing education be supported by public funds administered by a body the primary function of which is education.

XXVII That financial support be extended to the research program in nursing education proposed by the Mental Health Services Branch of the B. C. Department of Health and Hospital Insurance.

XXVIII That a careful study of the costs of our present hospital school programs be undertaken.

XXIX That there be no increase in the number of hospital schools as now constituted.

XXX That sufficient financial assistance be made available to students to ensure that aptitude and interest rather than financial considerations determine the extent of their educational preparation.

XXXI That the University of British Columbia School of Nursing be provided with necessary funds and facilities to enable it to expand enrolment in the basic degree program so that by 1980 it can accommodate up to 20% of the students entering nursing in British Columbia.

XXXII That educational programs for the preparation of health workers (including but not confined to nurses) be planned on an interdisciplinary basis.

XXXIII That a program of continuing nursing education be undertaken by the School of Nursing of the





XXII That in planning health development  
provision for the hospital of lower level  
these care services, including hospital services  
XXIII That programs of the hospital of  
hospital care be initiated  
XXIV That nursing education be supported  
by public funds administered by a local government  
function of which is education  
XXV That hospital support be extended to  
the research program in nursing education proposed by  
the Mental Health Services Branch of the B. C. Department  
of Health and Hospital Insurance  
XXVI That a careful study of the costs of  
our present hospital social programs be undertaken  
XXVII That there be no increase in the number  
of hospital schools as now constituted  
XXVIII That additional financial assistance  
be made available to students to ensure that attitude  
and interest rather than financial considerations  
determine the extent of their educational preparation  
XXIX That the formation of British  
Columbia School of Nursing be provided with necessary  
funds and facilities to enable it to expand enrollment  
in the two degree program so that by 1955 it can  
accommodate up to 100 of the students entering nursing  
in British Columbia  
XXX That a new program of the  
preparation of health workers (nurses and not only nurses)  
to be planned on an interdepartmental basis  
XXXI That a program of continuing education  
education be undertaken by the School of Nursing of the



University of British Columbia (possibly in conjunction with the Department of continuing medical education), and that

- a) this program make available, on a regional basis, periodic refresher courses for inactive graduate nurses wishing to return to active practice;
- b) where indicated, interdisciplinary planning of and participation in continuing education programs be arranged;
- c) increased financial resources be made available to the University School of Nursing to make these expanded activities possible.

XXXIV. That nursing consultant services by members of the Faculty of the School of Nursing of the University of British Columbia be made available to hospitals and other health agencies in the Province, and that increased financial resources be made available to the University School of Nursing to ensure sufficient staff and funds to make these expanded services possible.

XXXV. That the University of British Columbia School of Nursing be provided with necessary funds and facilities to enable it to engage in a program of nursing research.

XXXVI. That there be summer session offerings of courses acceptable for credit toward a degree, planned by the Canadian universities on a regional basis to enable sharing of resources including faculty.

XXXVII. That there be established in Canada a sufficient number of Master's level programs in nursing



University of British Columbia, 1960-1961, in connection with the treatment of a patient in the medical laboratory and that

a) this program was developed, on a regional basis, for the purpose of training nurses within the province to practice;

b) where indicated, particularly in connection with the and particularly in connection with the practice of the program;

c) increased financial resources be made available to the University of British Columbia to enable these expanded activities to be carried out.

XXXXIV That nursing consultation services by members of the faculty of the School of Nursing of the University of British Columbia be made available to hospitals and other health agencies in the Province, and that increased financial resources be made available to the University of British Columbia to enable these activities to be carried out and funds to make these expanded activities possible.

XXXXV That the University of British Columbia School of Nursing be provided with necessary funds and facilities to enable it to carry on a program of nursing

XXXXVI That there be a special session of the Council of the University of British Columbia for the purpose of considering and recommending to the Council any action which may be required in connection with the carrying out of the program of nursing

XXXXVII That there be a special session of the Council of the University of British Columbia for the purpose of considering and recommending to the Council any action which may be required in connection with the carrying out of the program of nursing



to provide adequate numbers of senior nursing personnel  
-- e.g.

- a) Expert clinical nurses;
- b) Nurses capable of planning and administering educational programs in nursing, including inservice education in hospitals and other health agencies;
- c) nurses capable of planning, administering and supervising nursing services in hospitals and other health agencies;
- d) faculty for university nursing schools and senior faculty for non-degree basic programs in nursing.

XXXVIII      That post-baccalaureate programs in nursing be planned with the needs of the whole of Canada in mind, to ensure programs of good quality, avoid duplication of effort and enable individual universities to focus efforts on those areas for which their resources are best suited.

XXXIX              That regardless of focus, post-baccalaureate programs include an acceptable introduction to research methods and require all students to submit a report of a research (or field) study.

THE CHAIRMAN: We will now rise until two o'clock, when we will proceed with the submission of the Canadian Psychiatric Association.

---Luncheon adjournment.





to provide adequate numbers of senior nursing personnel

- a) Expert clinical nurses;
- b) Nurses capable of planning and administering educational programs in nursing, including inservice education in hospitals and other health agencies;
- c) Nurses capable of planning, administering and supervising nursing services in hospitals and other health agencies;
- d) Faculty for university nursing schools and senior faculty for non-university basic programs in nursing.

That post-graduate programs in nursing be planned with the needs of the whole of Canada in mind, to ensure programs of good quality, avoid duplication of effort and enable individual universities to focus efforts on those areas for which their resources are best suited.

That universities of focus, post-graduate programs include an acceptable introduction to research methods and prepare all students to submit a report of a research (or field) study.

THE CHAIRMAN: We will now rise until two o'clock, when we will proceed with the session of the Canadian Psychiatric Association.



A/ss

---Upon Resuming.

DR. JOBIN: Mr. Chairman, the first submission this afternoon is from The Canadian Psychiatric Association and their brief will be known as Exhibit No. 250. Dr. Dunsworth will introduce the delegation.

S U B M I S S I O N O F

THE CANADIAN PSYCHIATRIC ASSOCIATION

---EXHIBIT NO. 250: Submission of the Canadian Psychiatric Association.

APPEARANCES:

DR. F.S. DUNSWORTH

DR. ALDWYN STOKES

DR. C.A. ROBERTS

THE CHAIRMAN: Dr. Dunsworth.

DR. DUNSWORTH: I am Dr. Frank Dunsworth of Halifax. I am president-elect of the Canadian Psychiatric Association. I regret that Dr. Jean Saucier, our President is not available. He is over in Geneva representing Canada at the World Health Organization. On my right is Dr. Aldwyn Stokes, Professor of Psychiatry here at Toronto, and on my left is Dr. Charles Roberts who is Superintendent of a hospital at Verdun, Quebec. Dr. Stokes and Dr. Roberts have worked hard and long on this brief. If you do not mind, sir, I would like to ask them





Dunsworth. 9314

if they would go ahead and present it.

THE CHAIRMAN: Thank you, Dr. Dunsworth.  
Dr. Stokes: We follow an informal procedure and if you  
wish to sit down, please do so.

DR. STOKES: I think I would be more  
comfortable standing up to begin with.

The Canadian Psychiatric Association  
in its submission to the Commission has eleven recommenda-  
tions. The first four have relevance to the Association's  
immediate concern, namely that the Canadian services for  
the mentally ill be developed on the same basis as other  
health services.

I. THAT all medical care programs, with or without  
government participation, include psychiatric  
illness on the same basis as other illnesses.

II. THAT federal provincial hospital insurance pro-  
grams be amended to include mental hospitals.

III. THAT physicians, specializing in psychiatry or  
engaged in other areas of medical practice, who  
provide treatment directly to patients, be  
remunerated on the same basis as other physicians.

IV. THAT federal and provincial construction grants  
in the mental health field provide assistance  
only for those structural developments required  
to integrate mental health services with general  
health services.

That recommendation is relevant to the  
outmoded functions of the Canadian mental hospitals.

Following these four primary recommendations, sir, there  
are two recommendations, one relevant to training and one





I they would be glad to meet in

THE CHAIRMAN: Thank you, Mr. Chairman

Dr. Bishop, the report is before you and if you

would like to say anything, please do so.

Dr. Bishop: I think I would be more

comfortable standing up to begin with.

The Canadian Psychological Association

in its submission to the Commission has often recommended

that the first look have reference to the Association's

immediate concern, namely the Canadian services in

the mental field be developed on the same basis as other

services.

1. THAT all medical care programs, with or without

government participation, include psychiatric

illness on the same basis as other illnesses.

2. THAT general provincial hospital insurance pro-

grams be amended to include mental hospitals.

3. THAT physicians, specializing in psychiatry or

engaged in other areas of medical practice, who

provide treatment directly to patients, be

recommended on the same basis as other physicians

4. THAT federal and provincial governments

in the mental field provide assistance

only for those structural development projects

to improve mental health services with general

that recommendation is relevant to the

mental health of the Canadian mental hospitals.

Following these four primary recommendations, the

are the recommendations, one relevant to training and



Dunsworth 9315

to research, namely:

V. THAT federal and provincial funds, allocated for training and educational programs, be tripled.

VI. THAT federal funds, allocated for research in mental disorder, be augmented by \$400,000 a year to a total of \$5 million per year at the end of 10 years.

This is followed by three recommendations relevant to special problem areas in psychiatry.

VII. THAT psychiatric services for children be expanded and developed in community settings closely related to other children's services.

VIII. THAT psychiatric services for the aged be expanded and developed in community settings closely related to other geriatric services.

IX. THAT special problem areas of psychiatry (for example, juvenile delinquency, mental retardation, alcohol and drug addiction, psychopathic personality, forensic services, etc.) be developed through pilot projects and the appropriate application of their findings.

The object of that recommendation is to obtain firm facts on which to develop services in these difficult areas. Then finally, sir, in the last two recommendations we are concerned with the legislation which prevents the orderly development of psychiatric services in Canada.

X. THAT legislation, relevant to the admission of psychiatric patients to hospital and their legal status be revised.





Stokes 9316

And finally we know that economic aspects and financial implicatons exist in relation to it. We have done our best in an imperfect way to indicate something of the financial implications of our recommendations, but we feel that (XI.) the economic aspects and financial implications of these recommendations be the subject of special studies.

THE CHAIRMAN: Thank you very much, Dr. Stokes. Is there anything you wish to add at this moment, Dr. Roberts or Dr. Dunsworth?

I am going to ask Dr. Firestone to open the discussion on this.

COMMISSIONER FIRESTONE: Dr. Dunsworth, you and your associates are to be congratulated on a most comprehensive brief, both in terms of the coverage and in terms of submitting both evidence and estimates of requirements. One particular aspect that is outstanding, you have given us estimates of what it is going to cost to do all the things and implement all the things which you are recommending. Therefore, it gives us a certain concreteness, gives a certain concreteness to your recommendations that is helpful to us as Commissioners.

If I may follow up some of the specific and concrete recommendations you have made and try to establish how some of these recommendations could be implemented. My first question relates to your recommendation I, and I quote: "That all medical care programs, with or without government participation, include psychiatric illness on the same basis as other illnesses." You have given, sir, in your appendix 1 a summary of what voluntary medical







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agencies and organizations presently do. Would you say that this summary suggests that we are, in Canada, insofar as the prepayment of medical care services for psychiatric illnesses is concerned, we are still in the infancy of such development?

DR. STOKES: I would like Dr. Roberts to answer that.

DR. ROBERTS: I think we would agree that it is in the developmental stage.

COMMISSIONER FIRESTONE: Now, in looking over some of these plans as they are presently in existence I find a number of restrictions and limitations. What I would like to establish from you, is it a scheme along the line as it exists now that you are recommending or do you have something broader in mind. Perhaps the best way of getting to grips with this is by asking specific questions. For example, we find that in Ontario under the P.S.I. policies, and that is covered on Page 5 of your Appendix 1, you say that these plans, or one of their policies, includes psychotherapy by certified specialists in psychiatry, and you say the arrangement calls for paying \$5.00 per visit. Is my understanding correct?

DR. ROBERTS: That is correct, sir.

COMMISSIONER FIRESTONE: Does that cover the cost of the visit to the specialist in that field?

DR. ROBERTS: Psychotherapy is, perhaps, a unique form of treatment given by psychiatrists, and in its formal sense takes about fifty minutes for each



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specific questions. For example, we find that in Ontario  
under the E.M.I. policies, and that is covered on page 5

of your Appendix I, you say that these plans, or one of  
these policies, includes psychiatrically by certified

specialists in psychiatry, and you say the arrangement  
calls for paying \$2.00 per visit. Is my understanding

DR. ROBERTS: That is correct, sir.

DR. STOKES: Then it is correct, then that

cover the cost of the visit to the specialist in that

field.

a unique form of treatment given by psychiatrists, and  
in his formal sense takes about thirty minutes per case.



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visit. The prevailing rate across this country would go from \$15.00 to \$25.00 an hour. It is as stated here our feeling about \$5.00 per visit as paid represents about one-third of the fee which would be charged by a psychiatrist for such a service, which is a development in the right direction. We feel it could be developed and could meet the needs of the patient in terms of pre-payment.

COMMISSIONER FIRESTONE: If I understand you correctly, you are saying that it costs a person for his visit to the psychiatrist between \$15.00 to \$25.00; is that correct?

DR. DUNSWORTH: No, sir, that would be for an hour.

COMMISSIONER FIRESTONE: I am sorry, sir, I find it difficult to distinguish between what you call an hour and a visit. Is there a difference between fifty minutes and an hour as far as fees are concerned?

DR. ROBERTS: Generally the psychiatrist by the nature of psychotherapy is charging for time, not for technique, and not for some specific thing. Psychotherapy is the time given for this form of treatment. The general treatment is fifty minutes. If it is one-half hour, then it is half of the fee I mentioned that would probably be charged.

COMMISSIONER FIRESTONE: I am trying to relate what you are referring to in Paragraph B on Page 5 when you speak of \$5.00 per visit, I am trying to relate the \$5.00 covered under the plan to what the patient has to pay. Do I understand correctly that





visit. The traveling time across the country would be  
from 10 to 12 hours. It is as stated here that  
feeling about 10 to 12 hours as said before a month  
one-third of the time which would be charged by a  
psychiatrist for such a service, which is a novel point  
in the right direction. We feel it could be developed  
and could meet the needs of the patient in terms of pro-  
payment.

COMMISSIONER: If I under-  
stand you correctly, you are saying that it costs a  
person for his visit to the psychiatrist between \$10.00  
to \$25.00; is that correct?  
DR. SWARTZ: No, sir, that would be  
for an hour.

COMMISSIONER: I am sorry,  
sir, I find it difficult to distinguish between what you  
call an hour and a visit. Is there a difference between  
fifty minutes and an hour or for as fees are concerned?  
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for technique, and now for some specific thing. Psycho-  
therapy is the time given for the treatment.  
The general treatment is fifty minutes. If it is a  
particular case, that is a part of the fee. I mentioned that  
would probably be the case.

COMMISSIONER: I am trying  
to relate what you are saying to the agreement on  
page 5 when you speak of \$10.00 per visit, I am trying to  
relate the \$10.00 covered from the state to what the  
patient has to pay. Do I understand you correctly?



Roberts 9319

the equivalent amount the patient would pay for such a visit would be \$15.00 to \$25.00; is that correct?

DR. ROBERTS: That is correct.

COMMISSIONER FIRESTONE: Therefore, he would be paid, he would have an arrangement on a prepayment basis at the present time in existence under P.S.I. of 20% to one-third.

DR. ROBERTS: Yes.

COMMISSIONER FIRESTONE: \$5.00 being 20% of \$25.00 up to one-third, depending on the fee. Now, when you are making this recommendation which I quoted earlier, I take it you are in favour of prepayment plans that would cover both medical care services on physical health and on mental disturbances.

DR. ROBERTS: Yes.

COMMISSIONER FIRESTONE: Are you in favour of a plan that provides for 20 to 33% of the cost or are you in favour of a plan that would cover the total cost of psychiatric services?

DR. ROBERTS: We feel, I think, sir, that the patient should be entitled to obtain for psychiatric illness the same coverage he can obtain for physical illness. It is the practice in physical illness to pay 100% of the cost of service. We think psychiatric illness should be treated the same way. Our fundamental point here is that whatever the insurance program provides for physical care proportionately the same should be provided for any psychiatric illness.

COMMISSIONER FIRESTONE: Am I right in understanding, and we are dealing at the moment just





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with P.S.I., using that as an example, in cases of physical illness under the comprehensive plan of P.S.I. the total cost as appears on the schedule established in Ontario of the general practitioner would be covered.

DR. ROBERTS: I think that is correct, sir.

COMMISSIONER FIRESTONE: Your suggestion would be that the psychiatrist be treated in the same way. The psychiatrist is a specialist. Would you feel, therefore, that the specialist, his full schedule of fees governed by the Ontario schedule, or whatever schedule you are developing be also fully covered if the general practitioner is fully covered under the comprehensive plan?

DR. ROBERTS: If that is the development for other specialty services such as paediatrics, that the specialists' rate be 100% covered, we feel psychiatry should be the same. We don't feel we are competent to discuss the principles of co-insurance which might be used. We feel, however, that psychiatric illness should not be discriminated against, nor should the person providing the service.





Page 2

with P.C.I., being that as an example, it seems to  
physical fitness under the comprehensive plan of P.C.I.  
the total cost as compared with the actual cost, and  
Ontario of the General Practitioner would be covered  
Dr. Black: I think that is correct.

Yes.

would be that the psychiatrist be treated in the same way  
the psychiatrist is a specialist. Would you feel, there-  
fore, that the specialist, who is not a specialist or not  
governed by the Ontario schedule, or whatever, someone  
you are developing be also fully covered by the General  
Practitioner is fully covered under the comprehensive

Yes.

Dr. Black: Is that the develop-  
ment for other specialty services such as rheumatology,  
that the specialist's rate is 100% covered, we feel  
rheumatology should be the same, is that correct?  
concerned to discuss the principles of the comprehensive  
which be used. We feel, however, that the specialist's fitness  
should not be discriminated against, we are in fact  
again covering the service.



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Roberts

9321

COMMISSIONER FIRESTONE: In other words, you feel that you would want to be treated the same way as all the specialists in any medical care plan that is developed?

DR. ROBERTS: Correct, sir.

COMMISSIONER FIRESTONE: That is fair and clear recommendation, sir. Now, you were raising the question, just a little earlier, about any limitations that might be imposed on perhaps the question of co-insurance, as far as the patient is concerned. I am looking at your paragraph 5 on page 5, still dealing with the Appendix 1 in which you discuss the arrangements in existence in British Columbia and on page 6 of this appendix you say that this plan covers the psychiatrist continuing treatment on the basis of psychotherapy, the present limitation under our contract consists of a maximum of 15 hourly sessions or a monetary value of \$300.

Have you any views as to any possible maximum limitations for such service? Do you want to follow the sort of pattern that some plans have already accepted or would you like to go further and say that such a limitation may defeat the very purpose of a prepaid scheme for all these services, because if the patient is not cured after 15 sittings, and he hasn't got the money to pay for the remainder of these sittings, this may have been really an economic loss to the fund, to the plan and to society, as well as to the individual?

What are your views on the subject of limitation?





Roberts

9322

DR. ROBERTS: This quotation, sir, is used to illustrate the point you made first about the developmental phase. This is a plan that has progressed this far and the plan has been able to absorb this much without undue complications. Our feeling would be that basically a patient should be treated for as long and in the way appropriate to the patient's need.

I think we would prefer not to have this kind of limitation; that the patient would receive treatment as necessary and as indicated.

COMMISSIONER FIRESTONE: Well, this is very much to the point. Thank you for these comments. Now, in the developing stage of a more comprehensive plan without limitation as to the period or the number of visits that are required, what will your comment be on the claim which has been made in a report of the ad hoc Committee on Economic Aspects of the American Psychiatric Association quoted in paragraph 1(a) on page 6 of your appendix, where you say, and I quote:

"Emotional illness is so common that it would bankrupt the plan."

Would you agree with this observation?

DR. ROBERTS: Sir, there is a very practical limitation on the extent to which a plan could make expenditures in this field or in most health fields. There are in this country a limited number of psychiatrists and these psychiatrists can provide only so much service.

One of the ways of estimating the cost this year and in future years is to estimate the amount of service that can be provided, which certainly will not







Roberts

9323

meet the need and this kind of a statement illustrates the extensive morbidity of psychiatric illness but does not indicate in any way the extent to which we can possibly treat it. We do not have the resources to bankrupt a plan.

DR. DUNSWORTH: This is one of the objections that has been used.

COMMISSIONER FIRESTONE: I appreciate that. I would like to have your views and your attitude on those objections because you appreciate that in order to develop recommendations on the subject we have to take account of those objections and we would like to have the views of the profession as to why you do not agree with this objection.

DR. DUNSWORTH: We do not agree with this objection whatsoever.

COMMISSIONER FIRESTONE: Why?

DR. DUNSWORTH: Many, many factors, sir.

COMMISSIONER FIRESTONE: What are they, sir?

DR. DUNSWORTH: One is, as Dr. Roberts mentioned, the number of psychiatrists available.

COMMISSIONER FIRESTONE: If we can stop at this point for one moment. This is a rather negative reply, sir, because all you are saying is there is an urgent need to do more but we haven't got the people to do it. Let us assume that the plan is developed that will encourage more people to go in this field. We will have more psychiatrists because you need more psychiatrists to provide the service.





Roberts

9324

Now, assuming that you have those more psychiatrists then this objection disappears. Can you give us objections that will hold when this supply of psychiatrists increases in number?

DR. ROBERTS: I think we would have to say that psychiatrists are physicians, as other people practising medicine, and the treatment that will be provided will be appropriate to the patient's need and we believe that the profession is capable of seeing that there is not over-abuse of our form of treatment, or other forms.

The practical possibilities of having enough psychiatrists to service our population the next 20 years are, in our opinion, very, very remote.

COMMISSIONER BALTZAN: Are all emotionally, or emotional and mental disturbances treated by psychiatric specialists?

DR. DUNSWORTH: No, sir. Many of them are treated very adequately and very well by their own physician.

COMMISSIONER BALTZAN: Would you care to extend it perhaps in a percentage that actually required specialized treatment?

DR. STOKES: Sir, I think that we are concerned here with the natures, multiple natures of psychiatric illness and we are looking at one group of psychiatric illnesses which are relatively prolonged. We require, as I am sure you do, actuarial statistics on this particular form of illness. We have no such actuarial statistics available but in terms of the







Stokes

9325

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2  
3 evolution, we have started on a low basis and have  
4 built up. There is an evolution towards a better  
5 coverage of such illness and insofar as that evolution  
6 is taking place, there has been no bankruptcy of a plan,  
7 as yet. We have referred, for example, to the P.S.I.

8 I am told recently this has gone up to  
9 \$12 from the \$5. This is a movement, a movement which  
10 P.S.I. now finds itself able to undergo.

11 In short, sir, we are in the process  
12 of evolution. We see that many, or most, psychiatric  
13 illnesses are short. We are concerned with some that  
14 are prolonged. In terms of this prolongation the needs  
15 of coverage become an actuarial matter on which we have  
16 no information.

17 COMMISSIONER BALTZAN: But you do not  
18 need, if I am right, expert psychiatrists for all types  
19 of mental illness?

20 DR. STOKES: No, sir.

21 COMMISSIONER BALTZAN: Emotional distur-  
22 bance?

23 DR. STOKES: No, sir.

24 COMMISSIONER BALTZAN: That is my  
25 question. Thank you very much.

26 COMMISSIONER FIRESTONE: Well, gentlemen,  
27 if I may continue on this point. This statement that you  
28 have presented to us on page 6, that emotional illness is  
29 so common that it would bankrupt the plan, raises the  
30 question of how common is emotional illness? After all,  
if we are going to insure services is mental illness a  
reason for many visits to the doctor; first to the





Stokes

9326

general practitioner and then referred, perhaps, to the specialist?

COMMISSIONER McCUTCHEON: We are all a little mad, aren't we, Dr. Stokes?

DR. STOKES: I think you put it very well, sir.

COMMISSIONER FIRESTONE: I would like to discuss that in the context of insurance treatment and this is in that context and I would appreciate your comments.

DR. ROBERTS: I think there has been a survey in Saskatchewan several years back of the general practitioners which indicated that of the order of half the patients being seen by general practitioners were suffering from functional illness, perhaps psychiatric illness and not physical disease.

There also have been surveys done in hospitals, general hospitals, indicating a high percentage of people suffering from illness. There is a considerable difference, though, between people who can be said to suffer from an illness and those who seek the service to have something done about the illness.

I believe we have to be frank and say we have no real statistics on the number of people who would come forward for treatment if they were assured that the cost of the treatment would be met.

COMMISSIONER FIRESTONE: Would you say, sir, assuming that your recommendation is adopted and the plan or plans are developed, that providing such comprehensive services, including the treatment of mental







Stokes

9327

disorders, would you say that once such a comprehensive plan is in existence that you would have enough psychiatrists to meet the need for all the requests for treatment?

After all, you recommend that an insurance scheme be introduced. People will then be covered. They will come to first the general practitioner and then the psychiatrist for help. Have you got enough psychiatrists to introduce the plan?

DR. STOKES: No, sir. We are well aware of this deficiency in terms of psychiatric strength. We are aware of it and we are doing something about it, in these terms: first of all, we are developing courses of psychiatry in the undergraduate medical schools so that the general practitioner will be better able to deal with those lesser illnesses and relieve, therefore, the psychiatrist of the malignant illnesses, shall we call them, for the ones that are serious.

Secondly, the universities are embarking on a strong graduate program and as you will see from another part of the brief, the present ratio of psychiatrists to population is one in 25,000 and I know we are aiming, in the next 10 years, to produce a ratio of one in 15,000.

This will have a tremendous - this will mean a tremendous load on the university. In fact, it will mean tripling the number of qualified psychiatrists who have, as you recall, four years of specialist training over and above their medical training.

It will mean tripling the educational



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the fact, would you say that this and a few others  
plan is in existence that you would have an  
trials to test the value of the new plan for

At the same time, you recommend the

insurance scheme as indicated. People will

of course. They will come to find the general

and then the psychiatrist will help. Have you

psychiatrists to interpret the plan?

aware of this deficiency in terms of psychiatry

strength. We are aware of it and we are doing something

about it, in these terms: first of all, we are

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schools so that the general practitioner will be

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illnesses, the psychiatrist will be trained in

shall we call them, for the cases that are

Secondly, the universities are expanding

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another part of the bill, the present ratio of

trials to population is one in 12,000 and I know we are

aiming, in the next 15 years, to produce a ratio of one

in 12,000.

This will have a tremendous effect

on the insurance fund on the national level. In fact, it

will mean raising the number of qualified

and have, as you know, 100 years of a

over and over again, medical

it will mean training



Stokes

9328

facilities to produce these pyschiatrists but in 10 years time, if this is done, then we will have a ratio of one in 15,000 which is about the ratio which now obtains in the United States and which is a smaller ratio than that which obtains in the U.S.S.R.

At that time we shall be about equivalent to what is happening in the States and other countries now.

COMMISSIONER FIRESTONE: Well, sir, on page 9, again of the Appendix 1, you have presented us with a quotation of the experience of a plan in operation in New York and the quotation reads:

"One of our early fears that there were not enough psychiatrists available has proven unwarranted, at least in the New York area."

Now, if such a plan as you are recommending is introduced in Canada, and assuming that a number of people will be treated by medical practitioners in the first place and only the more complicated cases be referred to the specialist, would you feel that this statement would hold in Canada or would we have a line waiting outside the office of the psychiatrist or it may take three to six months to get an appointment?

What sort of situation would you visualize once a plan comes into effect?

DR. STOKES: The position, I think, is again one that we can only see in terms of the process of evolution. In 1948 the ratio of psychiatrists to general population in Canada was somewhere around one in







Stokes : 9329

50,000. Now it is one in 25,000. The psychiatric services are, therefore, evolving and are evolving in terms of meeting the patient need.

In terms of the plan which we have presented to the Commission, in 10 years we will be able to get to a ratio of one in 15,000. This will be a better coverage, but not sufficient.

We think that the ultimate ratio will be one in 10,000 and that is, I think, probably - although it is bad business really to anticipate a matter of years ahead - this, we feel, will give a tremendous coverage in terms of what the specialist psychiatrist can do - not the general practitioner who will be better, but the specialist psychiatrist can do in terms of mental health needs.

DR. ROBERTS: I would like to add, sir, two comments. One of the purposes of having prepaid medical care for psychiatric illness is to remove the financial impediment and to allow the patient to feel that he has an illness and not something different. That being so, we believe that the provision of this insurance will then prove a correction of the distribution of medical manpower and that the medical practitioner will enter those fields where the need is produced and to this extent we think it will help to correct the situation which might possibly develop as you visualize it.





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Stokes 9330

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4 COMMISSIONER FIRESTONE: Your suggestion  
5 is, if I understood you correctly, you make the financial  
6 provision first to make it easier for people to go to a  
7 medical practitioner and then to the psychiatrist for  
8 help and then hope that the law of supply and demand will  
9 catch up and there will be an adequate number of trained  
10 psychiatrists forthcoming. Would you go further and say  
11 that you would want to accompany a program of comprehensive  
12 medical care coverage including psychiatric services with  
13 a bold, imaginative and constructive program of training  
14 and encouragement at the same time?

15  
16 DR. STOKES: At the same time is a  
17 crucial word, because this is the meaning of our conten-  
18 tion that the mental health service should be developed  
19 in a similar way to the general health services and if  
20 this is done, then the entrance to psychiatry of people  
21 who want to contribute in this difficult field of illness  
22 will be sufficient and allow the universities to take  
23 them up and will allow, therefore, the coming into the  
24 field of well-trained, well-qualified specialists.

25  
26 COMMISSIONER FIRESTONE: I can  
27 visualize that the final objective once it is reached in  
28 terms of both the demand for service and the supply of  
29 an adequate number of psychiatrists is a highly desirable  
30 objective, but I can also visualize some difficulties in  
the interim period between the day such a plan comes into  
operation and the day you have an adequate number of  
specialists in the field. Could you, therefore, visualize  
introducing a plan which you have in mind in two stages,  
one that would offer in the earlier stage a somewhat more







Roberts 9331

restricted coverage for prepaid psychiatric services with a very comprehensive and full coverage when you have enough psychiatrists to do the job?

DR. ROBERTS: The difficulties you envisage for the family or patient with psychiatric illness might not by any means be as difficult as they are at this time when a patient with coverage suddenly finds out that that coverage is for everything except mental illness and alcoholism and similar conditions; the insurance does not cover this. Also a concurrent difficulty which we have spent years trying to create is the attitude that mental illness is illness and then we say it is different, because of A, B, and C, and we say the difficulties which might occur, you have envisaged, would not be as serious as the present situation. We would prefer, I would say without any hesitation, we would not like a scheme modified for psychiatry.

COMMISSIONER FIRESTONE: You would prefer, in other words, to be put under pressure to provide the service and work harder to meet the requirements until you have colleagues to help you do the job, rather than limiting the demand.

DR. STOKES: Yes, we have some confidence in this point of view, because it is not a new plan, it is a plan which is coming about in terms of evolution. We have, in the past, had difficulties in terms of insurance coverage, in terms of being without available specialists and so on, but slowly these are moving in the direction we want and our submission to you





Stokes 9332

is really an extension of that evolution, an extension in the direction which we think is workable and with which we could, in cooperation with our confreres, play a proper part in the development of mental health services.

COMMISSIONER FIRESTONE: If you consider this for a moment; if this evolution takes time, takes you a good deal longer than ten years to achieve the objective that you have described, what I have in mind and my questioning has been based on this premise, and perhaps I might be at fault in not having elaborated the premise a little bit more. Let us assume now that a plan is developed whereby the Federal Government would offer financial assistance to Provincial Governments to introduce medical care service plans in their provinces in one form or another. Also let us assume that the provision be included with this such Provincial plan that Federal assistance would include both services, medical care service for physical illness as well as for mental illness. Therefore, you are faced, when such a plan comes into operation, with a substantial increase in psychiatric services. It was with that premise that my questioning has taken place.

My question to you now that I have spelled out the premise is, do you feel that when such provisions are made and one province or another accepts such a plan or develops them in a form suitable to everybody in the province and wanted by the people of the province, that you would have the bodies to provide such services. It is with this premise I ask you the question whether you feel that there would be enough







Roberts 9333

such bodies where a more limited scheme will be introduced initially to be broadened over a period of five or ten years?

DR. ROBERTS: We feel that this risk is one that should and could be taken. It is only a few years back we heard this kind of prediction about radiology in hospitals and the fact is, in spite of hardships and overwork, radiological services have been provided. We believe psychiatry is capable of responding in the same way as they did in radiology.

COMMISSIONER FIRESTONE: In other words, you feel a comprehensive medical care plan if it were introduced should cover provision for physical medical care service as well as mental medical care service at the same time?

DR. ROBERTS: Correct.

COMMISSIONER BALTZAN: It would help us a great deal if you would take it up from the other end and come up with some form of plan to reduce the number of psycho-neurotics. I am not being facetious. Is there a plan in that direction, in terms of repairing or restoring. What is the preventive element to reduce the number of psycho-neurotics?

DR. STOKES: There are two very important points here. First of all, as I have explained and we have agreed, the general family practitioner must play an increasingly important part in the early treatment of this illness which later develops into neuroses. Much more than that, however, we require more knowledge, we do not come before you confident in the full knowledge of





Stokes 9334

these illnesses. We do know that we have to study and research into them and part of our brief, as you recall, is a special emphasis on research. If we are researched properly, then the hope of diminishing the number of neuroses is greater, but much more than that, we know that the skills which the family doctor can exercise with these neurotic illnesses may, in great part, be dealt with.

COMMISSIONER BALTZAN: Which would then lessen the demands upon a greater and greater number of psychiatrists?

DR. STOKES: Exactly, sir.

COMMISSIONER FIRESTONE: That is a very helpful comment, Dr. Baltzan. To follow up that line of thinking, would you say, Dr. Roberts, that one of the reasons you would feel that existing bodies of psychiatrists could cope with the volume of work is that you would hope that early detection and treatment would reduce ultimately the services required to treat more serious cases which would take much longer and require more of the professional resources we have in this field which are limited. Is this part of your feeling?

DR. ROBERTS: Our feeling is if treatment was applied properly by the specialist or the general practitioner, that these people can function in the community, can contribute and play their part and treatment and the number of patients in hospitals, as in the present situation, could be changed markedly.

COMMISSIONER FIRESTONE: There are important economic implications in what you have been saying to us. I take it the economic implication is that





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these 11 papers. We do find that we have to study the research into them and put it out there, as you would. as a special emphasis on research. It was also research.

Now, even the hope of understanding the number of responses is greater, but what more than that, we know the skills which the early research can experience with respect to the research, in that part of the study.

THE NATIONAL ACADEMY OF SCIENCES, which would then assess the data, and a greater and greater number of scientists.

COMMITTEE ON THE FUTURE OF THE NATION: That is a very helpful comment, it is true. To follow up the time of this, would you say, Dr. Roberts, that one of the reasons you would feel that extending studies of research to could come with the volume of work is that you would hope that early data and treatment would reduce ultimately the services required to treat some of the cases which would have high health and require one of the professional resources we have in this field which are limited. Is this part of your feeling?

DR. ROBERTS: The feeling is that treatment was avoided properly by the association of the general population, that these people can function in the community, can contribute and be in the work and research, and the number of people in the field, as you would say, could be reduced.

THE NATIONAL ACADEMY OF SCIENCES: That is a very helpful comment, it is true. To follow up the time of this, would you say, Dr. Roberts, that one of the reasons you would feel that extending studies of research to could come with the volume of work is that you would hope that early data and treatment would reduce ultimately the services required to treat some of the cases which would have high health and require one of the professional resources we have in this field which are limited. Is this part of your feeling?



Roberts 9335

there could be substantial savings to society and to the nation in terms of reducing requirements for hospital beds in institutions, requirements for psychiatric services in institutions and reduced cost of treatment for those who do not require institutionalization simply because they would have been diagnosed and treated earlier, which would involve a saving in time, effort and money.

Am I correct in that understanding?

DR. ROBERTS: In terms of the number of hospital patients and on the assumption that a resident of this country who is able to function in the community means a saving to the economy. However, when you go along and say there may be a saving in the number of psychiatrists required or certain other services, we are so far behind the actual need that I would not expect any real dollar saving to occur in the foreseeable future.

COMMISSIONER FIRESTONE: Let us put it this way, there would be an economic saving to the nation that somebody who has been released from a hospital which is not requiring a hospital bed or they have completely recovered and may not require treatment but you are also saying there are offsetting factors that many of the patients in the institutions are not receiving adequate care and, therefore, what you would like to see is to have savings that may be achieved used to increase the care for those people who are still in institutions --- provide more care and better care?

DR. ROBERTS: It is our belief that every sick person is entitled to adequate treatment as required and there are in this country 70,000 patients who,





1  
2 in our opinion, do not get the treatment that would  
3 restore many of them to health in the community.

4 COMMISSIONER McCUTCHEON: This is not-  
5 withstanding the fact that this group of patients is a  
6 group for which the Government has assumed responsibility?

7 DR. ROBERTS: Has assumed responsibi-  
8 lity for custody, but not for treatment, and there is a  
9 world of difference in this day and age between custody  
and treatment.

10 COMMISSIONER FIRESTONE: Well, to come  
11 back to your recommendation 1, this is a very laudable  
12 objective. May I now ask you one basic question? How  
13 do you visualize to see this objective realized?

14 DR. ROBERTS: We would hope in terms  
15 of the present course of events that the plans now in  
16 existence, as they gain experience, would continue,  
17 namely, expansion as they gain experience. On the other  
18 hand, if the financial resources of the total Canadian  
19 community are brought into being we would hope that the  
20 situation which developed with hospital insurance would  
21 not occur, namely, that from the first it would be  
22 recognized that the total community has the same respon-  
23 sibility to the mentally ill as to the physically ill,  
24 and that they should be included from the first even  
25 though we could not accurately give a suggestion of the  
26 cost, nor can we clearly say what will happen in the  
27 areas of service.  
28  
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in our opinion, do not get the point that would

3 create many of them to begin in the community

withstanding the fact that this group of patients is a

group for which the Government has assumed responsibility

10. POINTS. Has assumed responsibility

lity for everybody, but not for themselves, and there is a

world of difference in this day and age between security

and treatment.

COMMUNICABLE DISEASES. Well, to some

back to your recommendation, this is a very fine

objective. May I now ask you one more question? How

do you visualize to see this objective reached?

10. POINTS. We would look in terms

of the present course of events that the plans now in

existence, as they gain experience, would continue,

namely, expansion as they gain experience. On the other

hand, if the financial resources of the total Canadian

community are brought into being we would hope that the

situation which developed with hospital insurance would

not occur, namely, that from the first it would be

recognized that the total community has the same respon-

sibility to the mentally ill as to the physically ill,

and that there should be inclusion on the first even

though we could not immediately give a suggestion of the

idea, nor can we clearly say what will happen in the

area of interest.



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But we feel strongly that this risk is much less than that which now exists in terms of insurance coverage for the mentally ill.

COMMISSIONER FIRESTONE: Well sir, you are making really a dual suggestion. You say we would like to see the voluntary plans and the commercial plans extended to cover mental illness. Some of them already cover it, perhaps not enough. How would you (a) want to see some of those limitations removed on those carriers which do not cover this type of illness, extend their coverage to it. This is a desirable objective. How could it be achieved? Is there anything the government could do, or is this up to the carriers, and what are you planning to do to persuade the carriers to do something about it?

DR. ROBERTS: We, sir, are in continuous contact with the prepaid medical and other plans, in an effort to have an improvement in the situation. We believe that the government could assist in actuarial studies, and assist in conveying the plans, the experience of other plans. We also believe the various governments have the right to supervise, if not to some measure direct the activities of insurance carriers, and some influence could be brought to bear that way.

COMMISSIONER FIRESTONE: Have you approached the commercial carriers to produce plans of this nature, or to extend existing plans to cover psychiatric services?

DR. ROBERTS: I am sure hardly any of us in positions of responsibility have not had



But we feel strongly that this risk

is much less than that which now exists in terms of

insurance coverage for the mentally ill.

You are making really a dual suggestion. You say we  
would like to see the voluntary plans and the commercial  
plans extended to cover mental illness. Some of them  
already cover it, and you are saying, how many more  
(a) want to see some of these limitations removed on  
those carriers which do not cover this type of illness,  
extend their coverage to it. This is a laudable  
objective. How could it be achieved? In some instances  
the government would be, or is, up to the carriers,  
and what are you planning to do to persuade the carriers  
to do something about it?

Dr. WAGNER: We, sir, are in continued  
contact with the general medical and other plans, in  
an effort to have an improvement in the situation. We  
believe that the government should assist in technical  
studies, and assist in conducting the plans, the expansion  
of other plans. We also believe the various governments  
have the right to regulate, if not to some measure  
direct the activities of insurance carriers, and some  
of these could be brought to bear on this  
problem. I think that the government should  
encourage the carriers to extend their plans to cover  
this matter, or to extend existing plans to cover  
psychiatric services.

Dr. WAGNER: I am sure that by now  
it is a question of responsibility, and we have





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4 conversations with major carriers.

5 COMMISSIONER FIRESTONE: With what  
6 result?

7 DR. ROBERTS: I believe the situation  
8 is much better than in the indemnity plans, and there  
9 is hope that if the further expansion of comprehensive  
10 coverage takes place the situation will be quite  
11 different to what it is now. They do not tend to have  
12 the same exclusion in the comprehensive that exists  
13 in some of these indemnity type programs.

14 COMMISSIONER FIRESTONE: These  
15 commercial, or medically-sponsored plans require a  
16 premium payment, and presumably the more comprehensive  
17 the plan the higher the premium that has to be paid.  
18 We have heard from various submissions, and there are  
19 a certain number of people who are classed as indigent,  
20 and medically indigent. Now sir, how would you like to  
21 see your objective, which is explained here in paragraph  
22 1, realized, as far as the treatment of people in  
23 this category is concerned?

24 DR. ROBERTS: Sir, this is a broader  
25 question than psychiatry. We are, as an Association,  
26 an affiliate of the Canadian Medical Association. Our  
27 position has been stated, and we feel this very clearly,  
28 our aim is to provide for our patients, or to have  
29 provided for our patients and for the people providing  
30 service, the same program as that provided for the  
physically ill. There are broad philosophical questions  
of how this should be done. We leave to the broader  
working group the matter of the question of the more





conversations with major carriers.

DR. KOTLIKOFF: I believe the situation

is much better than in the industry class, and there is hope that if the further expansion of comprehensive coverage takes place the situation will be quite different to what it is now. They do not want to have the same exclusion in the comprehensive that exists in some of these industry type programs.

commercial, or medically-responsive plans require a premium payment, and presumably the same comprehensive the plan the higher the premium that has to be paid. We have heard from various submissions, and there are a certain number of people who are classed as indigent, and medically indigent. Now say, not would you like to see your objective, which is explained here in paragraph 1, realized, as far as the treatment of people in this category is concerned?

DR. KOTLIKOFF: Yes, this is a broader question than psychiatry. We are, as an association, an affiliate of the American Medical Association. Our position has been stated, and we feel this very clearly, our aim is to provide for our patients, or to have provided for our patients and for the people providing service, the same program as that provided for the physically ill. There are three philosophical questions of how this should be done. We leave to the program working group the matter of the question of the more



Roberts

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4 general policies involved.

5 COMMISSIONER FIRESTONE: Well, we  
6 appreciate that. I take it though that you would like  
7 to have people in these income brackets that we have  
8 described as the indigent and the medically-indigent  
9 to be provided with a service like the rest of the people  
10 in Canada who can afford to pay for such service, prepaid  
or otherwise, is that correct?

11 DR. ROBERTS: That is correct sir.

12 COMMISSIONER FIRESTONE: Can you  
13 visualize any other way of having the requirements of  
14 this group of people looked after but through payment  
of the State?

15 DR. ROBERTS: We would perhaps, sir,  
16 like to make some remarks on that point. Payment by  
17 the State involves one aspect of the provision of  
18 medical care, organization and direction by the State  
19 involves quite another aspect, and if our recommendation  
20 and our appendices are read, I think it becomes quite  
21 apparent that we feel that there has been over-centraliza-  
22 tion, over-direction of mental health services, to the  
23 point that they have not kept up with developments in  
24 the rest of health in this country, and we feel that  
25 however financed, there should be provision for local  
26 community participation in the direction of the program,  
and it should be oriented to the community and not  
directed from some central office.

27 COMMISSIONER FIRESTONE: Well, I  
28 take it you are concerned about government interference  
29 with the practice of psychiatry, but do you have objections  
30



general not else involved.

COMMITTEE ON FINANCIAL MATTERS

appropriate that I take it through that you would like

to have people in these income brackets that we have

described as the relevant and the necessary-instrument

to be provided with a service like the rest of the people

in Canada who are asked to pay for such services, especially

or otherwise, is that correct?

DR. FORTIN: That is correct.

COMMITTEE ON FINANCIAL MATTERS

realize any other way of having the requirements of

this group of people looked after but through payment

of the State?

DR. FORTIN: We would perhaps, sir,

like to make some remarks on that point. Payment by

the State involves one aspect of the provision of

medical care, organization and direction by the State

involves quite another aspect, and if our recommendation

and our apprehensions are real, I think it becomes quite

apparent that we feel that there has been over-centralization

tion, over-direction of mental health services, to the

point that they have not kept up with developments in

the rest of health in this country, and we feel that

laws or financial, there should be provision for local

community health action in the direction of the province,

and it should be referred to the community and not

directed from the central office.

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with the production of health care, but do you have concern





Roberts

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3 to government paying for the services rendered by  
4 psychiatrists to people who cannot pay for this service.  
5 This to me is a different question than interfering  
6 with the practice of medicine.

7 DR. ROBERTS: If the community sees  
8 fit to provide payment through the agency of government,  
9 with due protection to the profession responsibilities  
10 we have, we don't think we would have the right to  
11 object, but with due protection for our professional  
12 freedom and rights.

13 COMMISSIONER FIRESTONE: This is a  
14 very fair observation. Could you explain to us what  
15 you have in mind in using the phrase with due protection  
16 to your professional freedom?

17 DR. ROBERTS: Our primary responsibility  
18 should always be to the person who is seeking help  
19 in a community, and we should be free to provide this  
20 without concern for central directives regarding how  
21 we should work with the patient, the way in which we  
22 shall work with the patient, and the way in which our  
23 patient shall receive treatment, and we feel that if  
24 the pattern of care historically in this country is  
25 examined the limitation of these services and many other  
26 factors, would indicate that the provision of service  
27 to date has not been dictated by the needs of patients.

28 COMMISSIONER FIRESTONE: In other  
29 words, you would like to have full freedom to treat  
30 patients as you feel is desirable in the light of your  
knowledge and the advancement of science, and the  
treatment of patients, but you have no objections if the



to government paying for the services rendered by  
physicians to people who cannot pay for their services.  
This to me is a different question than in connection  
with the practice of medicine.

DR. ROBERTS: If the community sees  
it to provide payment through the agency of government,  
with due protection to the professional responsibilities  
we have, we don't think we would have to resort to  
obedience, but with due protection for our professional  
freedom and rights.

CONGRESSIONAL COMMITTEE: There is a  
very fair observation. Could you explain to us what  
you have in mind in using the phrase "with due protection"  
to your professional freedom?

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in a community, and we should be free to provide this  
without concern for central directives regarding how  
we should work with the patient, the way in which we  
shall work with the patient and the way in which a  
patient shall receive treatment, and we feel that if  
the pattern of care is established in that way, it  
excludes the limitation of these services and when we  
speak, would indicate that the provision of services  
to date has not been dictated by the mode of payment.  
The pattern of care is established in that way, it

words, you would like to have the freedom to treat  
patients as you feel is necessary in the light of your  
knowledge and the advancement of medicine, and the  
treatment of patients, but you are not objecting to the



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4 cheque for the service which you have rendered would  
5 come from a government department or a commission on  
6 behalf of the group that I mentioned, people that cannot  
7 pay for it. Would you feel that the fact that you may  
8 receive at the end of the month, or your members may feel  
9 that at the end of the month they receive a cheque  
10 covering treatment you may have given to medically  
11 indigent and indigent people, would that in any way  
12 interfere with your freedom to treat the patient as you  
13 see fit?

14 DR. ROBERTS: When you limit the  
15 question strictly to the fact that a cheque for payment  
16 is passed, I would not think that we have an objection,  
17 but if there are implications in certain controls,  
18 either of the patient or physician by the passing of  
19 that cheque, we might have to take a different position.

20 COMMISSIONER FIRESTONE: What kind of  
21 controls?

22 DR. ROBERTS: How often can a patient  
23 be seen? When can a patient be seen? Which doctor  
24 may see the patient? Under what circumstances of  
25 privilege and responsibility may the patient be seen,  
26 and these are things that we hold to be of the essence  
27 in the care of our patients.

28 COMMISSIONER FIRESTONE: If there were  
29 a limitation, let us say similar to what the B. C.  
30 scheme has ---

THE CHAIRMAN: Dr. Roberts rejected  
those long ago. He said he does not want those.

DR. ROBERTS: Well, the insurance plan



...for the service which you have rendered, would  
...from a government department or a commission on  
...of the group that I mentioned, people that cannot  
...for it. Would you feel that the fact that you may  
...at the end of the month, or your members may feel  
...that at the end of the month they receive a cheque  
...covering treatment you may have given to patients  
...indigent and indigent people, would that in any way  
...interfere with your freedom to treat the patient as you  
...see fit?

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...question strictly to the fact that a cheque for payment  
...is passed, I would not think that we have an objection,  
...but if there are limitations in certain controls,  
...either of the patient or physician by the passing of  
...that cheque, we might have to take a different position.  
COMMISSIONER FERNSTON: What kind of  
...controls?

DR. ROBERT: How often can a patient  
...be seen? When can a patient be seen? Which doctor  
...may see the patient? Under what circumstances of  
...privilege and responsibility may the patient be seen,  
...and these are things that we hold to be of the essence  
...in the care of our patients.

COMMISSIONER FERNSTON: If there were  
...a limitation, let me say something to what the B. C.  
...scheme has ---  
...of the B. C. scheme, rejected  
...those long ago. He said he does not want these.  
DR. ROBERT: Well, the question is...





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3 may provide this. It may be necessary for us to provide  
4 more. We would be responsible for letting our patient  
5 know exactly what the situation is. If the patient had  
6 more service and had to pay, presumably they would pay.  
7 If they couldn't, I imagine that in one way or another  
8 they would be treated.

9 COMMISSIONER FIRESTONE: In other  
10 words, you do feel that people in the indigent and  
11 medically-indigent group should get full treatment until  
12 they are well, and the fact that the cheque would come  
13 from the government would not in any way affect the  
14 quality of service?

15 DR. ROBERTS: Subject to the points I  
16 made, that is correct.

17 COMMISSIONER FIRESTONE: Might I turn  
18 to another subject altogether, if I may. You deal on  
19 page 41 with the costs of mental illness. It is page  
20 40, where you speak of the direct cost of mental illness,  
21 and page 41 where you deal with the indirect cost of  
22 mental illness. This is one of the sections that is  
23 supported by appendices subsequently, which are particularly  
24 helpful to us. You say on page 40 that your estimated  
25 cost at the present time is approximately \$240 million,  
26 and you then produce a forecast that this cost  
27 may rise to \$414 million in 1970, and you deal with this  
28 on page 7 of Appendix 18.

29 On page 41, sir, you provide us with  
30 an estimate of the indirect cost of mental illness,  
which you define as the economic loss to society due  
to people staying in a hospital, or people being outside





may provide this. It may be necessary for us to provide more. We would be responsible for letting our patient know exactly what the situation is. If the patient had some service and had to pay, presumably they would pay. If they couldn't, I imagine that in one way or another they would be treated.

COMMISSIONER: FIRST QUESTION

Now, you do feel that people in the indigent and medically-indigent group should get full treatment until they are well, and the fact that the charges would come from the government would not in any way affect the quality of services?

DR. ROBERTS: Subject to the points I

made, that is correct.

COMMISSIONER: SECOND QUESTION

to another subject altogether, if I may. You deal on page 41 with the costs of mental illness. It is page 40, where you speak of the direct cost of mental illness and page 41 where you deal with the indirect cost of mental illness. This is one of the sections that is supported by appendices on page 42, which are particularly helpful to us. You say on page 40 that your estimate cost at the present time is approximately \$250 million, and you then produce a forecast that this cost may rise to \$450 million in 1975, and you deal with this on page 7 of Appendix 18.

On page 41, sir, you provide us with an estimate of the indirect cost of mental illness, which you define as the economic loss to society due to people staying in a hospital, or because being unable



Roberts

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3 a hospital, but being unable to work, and you say that  
4 in your estimation the loss to the nation currently  
5 because of mental illness of one type or another is  
6 \$626 million. Now sir, if the comprehensive  
7 program which you envisage were introduced, we would  
8 according to your estimates be spending \$414 million  
9 by 1970. What would be the result of that increased  
10 spending, in addition to a healthier population? And  
11 I am directing my question to you in economic terms.  
12 Would we still be losing \$626 million, or would there  
13 be a significant gain because more people would be  
14 working that otherwise couldn't have worked?

14 DR. STOKES: I am no economist, and  
15 I prepared this particular working paper. Of course,  
16 they are just figures. They have some reality, but  
17 perhaps not much.

18 COMMISSIONER FIRESTONE: They are  
19 estimates?

20 DR. STOKES: They are estimates sir,  
21 and I think in this particular section I make the point  
22 that the hope by increasing service and increased cost  
23 was to reduce the indirect costs, and I believe that to  
24 be the substantial idea behind this particular brief.

25 In short, that if the direct costs are raised  
26 from \$200 million to \$400 million then to that extent  
27 indirect costs are reduced from \$626 million to something  
28 we don't know what.

29 Of course, this does turn on a notion  
30 of full employment, and I think that here we must make  
that particular point clear in providing these estimates.







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4 The interest which we psychiatrists have in getting  
5 employment to people who have been mentally ill is a  
6 very high interest indeed, and I think that with an  
7 implementation of better service, the whole pattern  
8 of relationship to the community will be bettered  
9 generally, will mean a better employment situation for  
10 the patient who is now better from a mental illness,  
11 but in direct reply to your question, it was the thinking  
12 that by increasing the direct costs, and thinking  
13 economically, regardless of the humanitarian aspect  
14 of the situation, that by increasing the direct costs  
15 we would diminish the indirect costs.

16 COMMISSIONER McCUTCHEON: You are not  
17 suggesting that you would necessarily diminish the  
18 indirect costs by as much as you increase the direct  
19 costs?

20 DR. STOKES: Not directly.

21 COMMISSIONER BALTZAN: Have you made  
22 any allowance for that neurotic drive and urge upon  
23 people who work twice as hard and save twice as much  
24 money?

25 DR. STOKES: Sir, you have raised a  
26 point which I didn't include to my advantage in this  
27 brief.

28 COMMISSIONER FIRESTONE: As I read  
29 the note that you have attached to table 2 on page 41,  
30 you say:

"In a year of full employment this is  
"likely to be an underestimate".

Therefore, I presume that this estimate is not based on





the interest which we psychiatrists have in restoring  
employment to people who have been mentally ill is a  
very high interest indeed. And I think that with an  
implementation of better service, the whole pattern  
of relationship to the community will be bettered.  
Generally, will mean a better employment situation for  
the patient who is now better from a mental illness,  
but in direct reply to your question, it was the thinking  
that by increasing the direct costs, and thinking  
economically, regardless of the humanitarian aspect  
of the situation, that by increasing the direct costs  
we would diminish the indirect costs.

COMMITTEE MEMBER MONTGOMERY: You are  
suggesting that you would necessarily diminish the  
indirect costs by as much as you increase the direct  
costs?

COMMITTEE MEMBER BARTON: Have you any  
any allowance for that nervous drive and urge that  
people who work twice as hard and save twice as much  
money?

DR. MONTGOMERY: Sir, you have a belief  
point which I didn't include in my statement is the  
point.

COMMITTEE MEMBER MONTGOMERY: Is it all  
the more that you have attempted to label it in page 11,  
in a year or two a question of it is  
"I feel to be an unbalanced person."  
Therefore, I presume that this literature is not for sale



Roberts

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4 full employment but on less than full employment?

5 DR. STOKES: Sir, in the appendix  
6 you will note that in terms of the indirect cost due  
7 to hospitalization, due to people being in a mental  
8 hospital, I took only the male population, and I am  
9 afraid I did that in order to be able to answer this  
10 point, that this is not an overestimate, but rather  
11 an underestimate, and in terms of full employment we  
12 would assume that both male and female also diversely  
13 are employed. In terms of a situation where there is  
14 some unemployment, presumably the burden might fall  
15 upon the women first, but at any rate there would be  
16 a reduction which would not be significant in terms  
17 of my estimate, which took men only, leaving out the  
18 women.

19 COMMISSIONER FIRESTONE: Let us assume  
20 for a moment that you would not introduce the program  
21 which you have recommended, and therefore as our  
22 population grows, our indirect loss would be a good deal  
23 more in 1970 than in 1960. They may be as much as 30  
24 or 50% more by 1970. In other words, you are talking  
25 really in 1970 of something like a loss of nine hundred  
26 to a billion dollars. Is that the sort of thing that  
27 you would anticipate, because I am trying to relate  
28 your 1970 figure of loss to your 1970 figure of costs?  
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full employment but on less than full employment?  
 Dr. Liska: Yes, in the appendix  
 you will note that in terms of the present cost due  
 to hospitalization, due to people being in a mental  
 hospital, I took only the male population, and I am  
 afraid I did that in order to be able to answer this  
 point, that this is not an overestimate, but rather  
 an underestimate, and in terms of full employment we  
 would assume that both male and female also diversely  
 are employed, in terms of a situation where there is  
 some unemployment, presumably the burden of that fall  
 upon the women first, but at any rate there would be  
 a reduction which would not be significant in terms  
 of my estimate, which took men only, leaving out the

COMMITTEE: (1915) Let us assume

for a moment that you would not introduce the program  
 which you have recommended, and therefore as a  
 population grows, our indirect loss would be a good deal  
 more in 1970 than in 1960. They may be as much as 30  
 or 50 more by 1970. In other words, you are talking  
 really in 1970 of something like a loss of nine hundred  
 to a billion dollars. Is that the sort of thing that  
 you would anticipate, because I am trying to relate  
 your 1970 figure of loss to your 1970 figure of costs?



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4 DR. ROBERTS: I get the point. I  
5 think in trying to present the situation for 1960 in  
6 terms of direct costs and indirect costs, and then  
7 going to 1970, I was merely concerned to give an  
8 estimate of the plan which we were developing, the plan  
9 which we hope, despite the increase of population and  
10 despite, perhaps, the increased immigration and the  
11 stress and turmoil of life, would increase the indirect  
12 costs so that the \$490 wouldn't be related to the \$600  
13 million, but rather to eight hundred or nine hundred or  
14 whatever it might be.

15 COMMISSIONER FIRESTONE: Exactly.  
16 Therefore, what you are saying, sir, if I understand  
17 you correctly, is that you are presenting a program  
18 which in 1970 would cost 414 million, an increase of  
19 173 million over 1960, and if we don't introduce such a  
20 program, incur losses in the year of eight or nine hundred  
21 million and if such a program were introduced, expansion  
22 of the program, the losses might be kept at the 1960  
23 level. Is that your point?

24 DR. ROBERTS: That is the direction I  
25 am thinking. The actual figures, of course, are not as  
26 clear-cut as that.

27 COMMISSIONER FIRESTONE: That is good  
28 enough, sir, because what this suggests, if my under-  
29 standing of what you are saying is correct, and if it  
30 isn't, please correct me, is that we may gain more in  
saving in indirect costs than it may cost us in expanding  
the program in direct costs?

DR. ROBERTS: I would underline that







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particular position, sir. I hope sincerely that this is the case.

COMMISSIONER FIRESTONE: You have been most helpful, sir. Thank you very much, all of you.

THE CHAIRMAN: Thank you very much.



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particular position, and I am not sure that it is the case  
that the position is not the same as it was in the past  
and that the position is not the same as it was in the past  
and that the position is not the same as it was in the past



DR. JOBIN: The next submission will be from the Canadian Heart Foundation and will be Exhibit No. 251. Dr. Segall will introduce the delegation.

--- EXHIBIT NO. 251: Submission of the Canadian Heart Foundation.

SUBMISSION OF THE CANADIAN HEART FOUNDATION

Appearances: Dr. H.N. Segall  
Mr. J.S. Dinnick  
Dr. J.B. Armstrong

DR. SEGALL: Mr. Chairman and Commissioners, firstly let me bring the greetings and regrets of the Right Honourable Mr. Louis St. Laurent, who is President of our Foundation but who could not be here today.

Then, I would like to introduce my colleagues. On my left, Mr. John Dinnick, a former Vice-President of the Canadian Heart Foundation and on my right, Dr. John Armstrong, an Executive Director of the Foundation.

THE CHAIRMAN: Dr. Segall, would you like to sit down?

DR. SEGALL: I will, thank you.

SUMMARY

S.1 This brief is submitted on behalf of the Canadian Heart Foundation, an organization dedicated to combatting the cardiovascular diseases, the primary cause of death and disability in the civilized world. It will affirm that generous support of medical research is essential to modern medical training, to







Segall

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ensure that the best possible health care is available to all Canadians. The Canadian Heart Foundation is competent to address itself to the requirements for medical research in the cardiovascular field.

S.2 This submission is concerned with the following paragraphs of the Order in Council P.C. 1961-883:

"e) Methods of providing adequate personnel with the best possible training and qualifications for such services; and

j) The relationship of existing and any recommended health care programs with medical research and the means of encouraging a high rate of scientific development in the field of medicine in Canada."

S.3 The Canadian Heart Foundations devote over 80% of their total income to the study and prevention of cardiovascular disease through the support of research and to the dissemination of knowledge by professional and public education. The Foundations complement the research activities and facilities in Canadian medical schools and teaching hospitals, and by means of education, the work of the medical profession, in the control of cardiovascular disease.

S.4 Canadians may well be proud of the accomplishments of their scientists but they have failed to show commensurate enthusiasm for the support of medical research with that of other countries. Canada lags far



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Segall

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behind the United States, which is particularly serious as Canadian universities and research institutions compete with their American counterparts for the same Canadian talent.

S.5 The primary need is adequately-trained manpower. At present, grossly inadequate provision is made for the young medical scientist aspiring to become a part of a medical school. With limited funds at their disposal, the universities cannot afford to engage the untried.

S.6 To provide for the future requirement of adequately trained personnel, the primary need in Canada is to provide for the expansion of teaching staff, through the increased availability of Fellowship programs. Such programs will encourage and place in the universities the young scientist and teacher who is trained but untried.

S.7 To allow for an adequate number of highly trained personnel in the cardiovascular field who will provide health services, it is estimated that in the year 1980, \$2,500,000 will be required for a Fellowship-type program and \$30,000,000 for a Grants in Aid program.

S.8 The Canadian Heart Foundation makes the following specific recommendations, to ensure "that the best possible health care is available to all Canadians":

(a) that funds for new research facilities, that is for bricks and mortar and instruments, in Canadian





Behind the United States, which is the only country in the world that has a medical school in its capital, the United States is the only country in the world that has a medical school in its capital.

The United States is the only country in the world that has a medical school in its capital. The United States is the only country in the world that has a medical school in its capital.

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Segall

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medical schools come from other than  
research funds,

(b) that the administration of research  
in the Department of National Health  
and Welfare be separated from the  
National Health Program Administration,

(c) that all service functions in  
hospitals covered by the Hospital  
Insurance and Diagnostic Services Act  
be charged to the Hospital Services  
Commission in the respective province  
with a measure of the Commission's  
budgets covering investigative proce-  
dures being set aside to further the  
development of diagnostic and thera-  
peutic techniques,

(d) that as \$32,500,000 will be  
required annually for the support  
of cardiovascular research activities  
by 1980, three-fourths of this sum,  
or \$25,000,000 should be the responsi-  
bility of Government agencies. For  
the most effective use of research  
funds in the intervening years, it  
would be best if they were made  
available in a gradually increasing  
manner, annually. For the next  
four years, the research granting  
agencies of the Government of Canada  
in extramural programs, would provide:





Segall 9352

	<u>Fellowship-type</u>	<u>Grants in Aid</u>	<u>Total</u>
1962/63	\$150,000	\$1,500,000	\$1,650,000
1963/64	300,000	2,300,000	2,600,000
1964/65	450,000	3,300,000	3,750,000
1965/66	600,000	4,400,000	5,000,000

This, Mr. Chairman, is a summary of the brief we wish to present.

THE CHAIRMAN: Thank you, Dr. Segall. Have either Dr. Armstrong or Mr. Dinnick anything to add at this moment?

MR. DINNICK: No, sir.

DR. ARMSTRONG: Not I, sir.

THE CHAIRMAN: Dr. Baltzan?

COMMISSIONER BALTZAN: Mr. Chairman, I welcome Dr. Segall as the pioneer of the heart movement in Canada, figuratively and literally, and also his colleagues. I don't have any questions for you, Dr. Segall, but I will ask you to please explain for better understanding just two things.

I would refer you to page 2, S.8(b): "that the administration of research in the Department of National Health and Welfare be separated from the National Health Program Administration" My question one: do you mean to make two departments or two separate accountancy departments?

DR. SEGALL: Commissioner Baltzan, Mr. Chairman, may I ask Dr. Armstrong, who is an expert on this particular question, to explain what is meant?

DR. ARMSTRONG: Mr. Chairman, the







Armstrong

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intention is not to have two departments, but merely to separate the administration of the research aspect of the National Health Program from the rest of the administration. If I may very briefly; historically the National Health Program was initiated in 1948 and at that time the research aspect of it was a very minor part of the whole. The whole program was set up on the basis of a drawing account.

It would seem to the Heart Foundation that if the administration of the research program within the Department of National Health and Welfare was set up in a manner similar to that practised by the Medical Research Council, the Defence Research Board, indeed practically all other agencies in the field of medical research, that it would work more effectively and more efficiently. It is not suggested, sir, that it would be outside the Department of National Health and Welfare.

COMMISSIONER BALTZAN: I understand, thank you. On page 3 at the top of the page, (c):

"that all service functions in hospitals covered by the Hospital Insurance and Diagnostic Services Act be charged to the Hospital Services Commission in the respective province with a measure of the Commission's budgets covering investigative procedures being set aside to further the development of diagnostic and therapeutic techniques"

I am very pleased to see your emphasis on this provision. Would you just emphasize your purpose?





Segall

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DR. SEGALL: Perhaps Dr. Armstrong would answer that also.

DR. ARMSTRONG: Well, Mr. Chairman, the practice has been, in Canadian medicine, at least, for new developments to be underwritten entirely by research funds, and these new developments, the payment for these developments, well after they are long established as a routine procedure, still comes out of research funds. There are many examples of this in many of the hospitals across Canada. It is intended by this suggestion, this recommendation, that under the Hospital Insurance and Diagnostic Services Act there be provision made for the development of new techniques and investigative procedures - that this become the responsibility, at least, in part, of the Hospital Services Commission so that these new developments will not be dependent entirely on research resources.

COMMISSIONER BALTZAN: You want to have patient care costs delineated and these investigative procedures which are part of the function of hospitals and medical centres, be kept separate and not be put on to the care of patient costs?

DR. ARMSTRONG: I am sorry, sir, I think there is, perhaps, confusion between what might be known as technological developments as against the experimental research program. The experimental research program would come from the medical research granting bodies, but technological developments, such things as radioactive ionization, heart cauterization, heart-lung machines - these procedures are supported out of medical







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TORONTO, ONTARIO

Armstrong

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research funds long after they have become a routine  
procedure. It would seem not improper for the Diagnostic  
Services Act to make an allowance for a certain element  
of technological developments as part of its responsibilities,  
and that funds for this purpose be made available  
through the various provincial Hospital Services  
Commissions.





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It is not intended, by this paragraph sir that the hospital insurance and Diagnostic Service Act would pay for experimental research, as such.

COMMISSIONER BALTZAN: That is exactly the point.

DR. SEGALL: Mr. Chairman, might I just add this word. I think this problem arises from the fact that in the past few years, and we can foresee in the next few years the rate, the progress in this particular field is so rapid that an instrument which costs many thousands of dollars and which instrument is experimentation in 1962, becomes an instrument of routine use in the care of patients as early as 1963.

Watch, therefore, should be made on the progress of events and the relationship of work to work so that materials and instruments which are actually doing productive routine work should not be charged to the research for experimental work.

COMMISSIONER BALTZAN: Contrary-wise too. In other words, you want to have sharp line of demarcation?

DR. SEGALL: Yes.

COMMISSIONER BALTZAN: That which belongs to medical care, even these things in the transition period, must be recognized as and provided for by the Hospital Commission.

DR. SEGALL: Yes.

COMMISSIONER VAN WART: Dr. Segall, if there is a change in the medical economic situation, do you believe that your organization should continue





It is not...  
and that the medical profession and the public are...  
not willing to pay for experimental research, as a...  
CONSTITUTIONAL MATTER: That is what...

DR. HUGHES: The question, which I...  
just and this was... I think this problem...  
the fact that in the past few years, and we can foresee  
in the next few years the rate, the progress in this  
cardiac field is so rapid that an instrument which  
costs many thousands of dollars and which instrument  
is experimentation in 1952, becomes a treatment of  
routine use in the care of patients as early as 1955.  
Watch, therefore, should be kept on  
the progress of events and the relationship of work to  
work so that materials and instruments which are  
actually doing productive routine work should not be  
charged to the research for experimental work.

too. In other words, you want to have sharp line of  
demarcation?

DR. HUGHES: Yes.  
CONSTITUTIONAL MATTER: That would...

belong to medical care, even these things in the  
transition period, must be provided as and provided  
for in the hospital legislation.

DR. HUGHES: Yes.  
CONSTITUTIONAL MATTER: Yes, I agree,  
there is a change in the medical economic situation,  
do you believe that your organization should continue



Segall

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as a voluntary organization functioning as at present?

DR. SEGALL: I think that is a question that I will have much pleasure in turning over to Mr. Dinnick who is one of the ace procurers of money for medical research in this country. Mr. Dinnick?

MR. DINNICK: I would like to answer that question in two parts. The question, as I understand it, is if we get all the money that we require from the Government is there a place for the voluntary aspect still in the community or in the country?

COMMISSIONER VAN WART: Yes.

MR. DINNICK: Well, I will answer it first by saying there are two ways in which you can get good men to work. You can get them by paying for them or you can get them by asking them to do something for nothing.

By far the best way to get them is to do something for nothing, and by far the best men are available on this basis.

On our Board of Directors, a copy of which is attached, you will see that Mr. St. Laurent could hardly be paid \$1,000.00 a year to be president of our Foundation. Nor Mr. Ambridge, nor Mr. Hill, Mr. Sedgwick and I think we would be wasting a great deal of valuable talent to our field of ideas if we did not use their willingness to work for nothing.

So first of all, we would lose the benefit of their advice in our council.

Secondly, I think there is two sides. The way we are going now with the demand for money, if





Dinnick

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4 we do not get some help from the Government we are  
5 going to be bankrupt. We can see, for example, in the  
6 program that is laid before us by competent doctors  
7 that we are vetting down all the applications we have  
8 to try and see how many we can pay off out of our  
resources.

9 We can either cut the program off  
10 and remain solvent or can say let's do everything  
11 worthwhile and go bust.

12 In Ontario, which is the largest  
13 segment of this, we figured at our last meeting in two  
14 years, at our current rate of expenditure, we would  
15 finish all the small amount of money we had left over.  
16 That is the direction in which we are headed so that  
17 what we would like is more support but if you have got  
18 too much support, if the Government took the whole  
19 requirement over, I would be against that too because  
20 the second you gave us all the money we require, we  
wouldn't get a plugged nickel from the public.

21 I think there is a place for their  
22 interest in this work. I would like to see the  
23 Government have an elastic purse. If we make a break-  
24 through and need \$5 million next year, we would get  
25 a lot more than we get now from the public and by the  
26 same token, we would have to have a generous Government,  
an understanding one, giving us the money we require.

27 So my answer is in two parts. Yes,  
28 there is a use for us on a voluntary basis and (b)  
29 do not give us all the money but have an open mind and  
30 a generous outlook in giving us what we require and we





we do not get some idea from the Government as to  
how to be bankrupt. We can see, for example, in the  
program that is laid before us by Congress that  
that we are getting down all the applications and  
let's see how many we can pay off out of our  
resources.

We can either cut the program off  
and remain solvent or we can say let's do everything  
worthwhile and so on.

In fact, which is the last  
segment of this, we think at our last meeting in two  
years, at our current rate of expansion, we would  
finish all the small amount of money we had left over,  
that is the direction in which we are headed so that  
that we would like to have some idea if you have not  
too much support, if the Government took the whole  
department over, I would be against that too because  
the second you gave us all the money we require, we  
couldn't get a piece of it out of the office.

I think there is a place for this  
interest in this work. I would like to see the  
Government have an elastic limit. If we need a piece  
through and need 25 million next year, we would get  
a lot more than we get now from the public and if the  
same token, we would have to have a somewhat government  
on understanding one, giving us the money we require,  
so my answer is in two parts, yes,  
there is a case for us on a whole, yes (b)  
to give us all the money that we need to open kind and  
a generous outlook in giving us what we require and we



Dinnick

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3 will try and find the rest from the public, as we are  
4 doing now and the chart shows we have progressively  
5 obtained more.

6 "When I say that We don't know whether next year we  
7 suddenly will have -- supposing, to quote an example,  
8 Dr. Bigelow who I understand for some time has been  
9 trying to prove -- if Dr. Bigelow was able to find a  
10 way of putting people into a state of hibernation  
11 through experiments he is carrying on with ground hogs,  
12 we discovered that this was something that could be  
13 usefully applied in medicine, he might need, I don't  
14 know how many millions of dollars and we would find  
15 them, an awful lot of them if it was demonstrated that  
16 this was an extremely valuable thing that suddenly had  
17 come to light so I say there is a place for us. We need  
a lot of money but we don't need it all.

18 COMMISSIONER McCUTCHEON: That discovery  
19 might have applications other than in the field of  
20 medicine.

21 MR. DINNICK: Yes, it could sir, very  
22 easily. We could use it out in British Columbia.

23 COMMISSIONER BALTZAN: You certainly  
24 are very charitable. This is the first time we have  
heard anyone say don't give us all the money we need.

25 MR. DINNICK: I think it would be a  
26 bad thing if we got it all.

27 THE CHAIRMAN: Well just on that,  
28 what you are suggesting is that of this build-up from  
29 1962 to '66 that the Federal Government provide \$5 million,  
30 I mean by 1966, as being a reasonable amount towards  
whatever the total may be?



...try and link the rest of the public. As we are  
doing now and the chart shows we have progressive  
a trained more.

We don't know whether next year we  
suddenly will have -- supposing, no photo an example,  
Mr. Bissell who I understand for some time has been  
trying to prove -- if Mr. Bissell was able to find a  
way of putting people into a state of hibernation  
through experiments he is carrying on with ground bees,  
we discovered that this was something that could be  
readily applied in a machine, no night need, I don't  
know how many millions of dollars and we would find  
them, an awful lot of them if it was demonstrated that  
this was an extremely valuable thing that suddenly had  
come to light so I say there is a place for us. We need  
a lot of money and we don't need it all.

COMMISSIONER MCCUTCHEN That discovery  
might have applications other than in the field of  
medicine.

MR. BISSILL: Yes, it could sir, very  
easily. We could use it out in British Columbia.

COMMISSIONER BATTMAN: You certainly  
are very optimistic. This is the first time we have  
heard anyone say don't give us all the money we need.  
MR. BISSILL: I think it would be a  
bad thing if we got it all.

MR. CHAIRMAN: Well just on that,  
what you are suggesting is that of this bill-keeping  
bill to be that the federal government provide as much  
I mean by 1950, as being a reasonable amount of money  
whether the total has not



Dinnick

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MR. DINNICK: Yes.

THE CHAIRMAN: Now you have an interesting observation in paragraph 35, on page 9: "When the British North America Act was written, health and education became Provincial responsibilities but research was not mentioned, and therefore the Federal Government can support medical research in any and all fields directly."

Now does this represent the considered opinion, the considered view of all your Provincial foundations?

DR. SEGALL: I would ask Dr. Armstrong to make comment on this. He introduced me to this point.

DR. ARMSTRONG: The question sir is does this represent the opinion of all our Provincial Heart Foundations?

THE CHAIRMAN: Yes, including the Quebec Foundation?

DR. ARMSTRONG: Well my answer sir is that this brief was circulated to all the Provincial Heart Foundations and they were given an opportunity to comment upon it. On this particular point we received no objections. I can say no more sir.

DR. SEGALL: Well, with regard to Quebec, let me say, as I come from Quebec, we did not have a meeting to consider this brief point by point so I don't think one can assume from the remarks of Dr. Armstrong that due consideration was given to it and that it was acceptable.







Segall

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I think we just should leave it in the open. We don't know whether it is acceptable or not.

COMMISSIONER McCUTCHEON: It is a practical matter. The Province of Quebec seems to have accepted that. I see in your appendix D that the largest or the greatest single grants from the Federal Government in the year 1961-62 go to the Province of Quebec.

DR. ARMSTRONG: That is true, yes sir.

THE CHAIRMAN: Total of 431,327 out of one million and twenty-eight for the country.

DR. ARMSTRONG: Yes.

COMMISSIONER McCUTCHEON: I would like to ask one other question on that. The total research support in Ontario from both the Heart Foundation and the Government is 866,000 with 542,000 coming from the Heart Fund, as I read the table. A corresponding figure for Quebec is 591 with 161. Does that represent the difference in the voluntary fund-raising for the two provinces?

DR. SEGALL: Yes.

MR. DINNICK: Our target in Ontario this year was \$600,000.00 of which we have achieved to date a little over \$500,000.00. In Quebec the total was \$250,000.00, was their target and how much did they raise?

DR. SEGALL: So far \$161,000.00. Hope to raise \$200,000.00.

MR. DINNICK: These figures are going



I think we just should leave it to the open, we don't know whether it is acceptable or

COMMISSIONER MONTGOMERY: It is a practical matter. The Province of Quebec seems to have accepted that. I see in your appendix D that the largest on the greatest single grants from the Federal Government in the year 1961-62 go to the Province of

MR. ARSTON: That is true, yes sir.  
 THE CHAIRMAN: Total of \$21,327 out of one million and twenty-eight for the country.

COMMISSIONER MONTGOMERY: I would like to ask one other question on that. The total we are supporting in Ontario from both the Heart Foundation and the Government is \$66,000 with \$42,000 coming from the Heart Fund, as I read the table. A corresponding figure for Quebec is \$51 with \$11. Does that represent the difference in the voluntary fund-raising for the two provinces?

MR. ARSTON: Yes.  
 MR. MONTGOMERY: Our target in Ontario this year was \$800,000.00 of which we have achieved to date a little over \$500,000.00. In Quebec the total was \$100,000.00, was their target and how much did they

MR. ARSTON: In the \$21,327,000.00, does to make \$100,000.00.  
 MR. MONTGOMERY: Does it mean any more?



Dinnick

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4 to be modified somewhat by the fact that we do distribute  
5 the national corporations insofar as insurance companies  
6 and banks are concerned pro rata to the provinces so  
7 they will benefit to a certain extent from some of the  
8 money we raised here which will funnel down to them.

9 THE CHAIRMAN: In connection with that  
10 table, is there any reason why the amount in the grand  
11 total, including Heart Foundation, and so forth, why  
12 the Province of Saskatchewan is so much below, proportion-  
13 ately below all provinces except Nova Scotia?

14 DR. SEGALL: Well, I will ad lib about  
15 that. I haven't got facts and figures. The unit in  
16 Saskatchewan is a new unit, the cardiovascular unit,  
17 so that the demands for funds for workers is not as  
18 great as elsewhere.

19 THE CHAIRMAN: Would that be the same  
20 explanation for Nova Scotia?

21 DR. SEGALL: Yes, in Nova Scotia the  
22 unit is even smaller and earlier in its development.

23 THE CHAIRMAN: And Prince Edward  
24 Island hasn't got one at all?

25 DR. SEGALL: Right.

26 COMMISSIONER McCUTCHEON: These are  
27 all situated in teaching hospitals?

28 DR. SEGALL: Yes. As you know  
29 Saskatchewan, I don't need to tell you, is a new unit.

30 THE CHAIRMAN: Thank you very much,  
Dr. Segall, Dr. Armstrong, Mr. Dinnick. You have been  
very helpful to us and we appreciate the time that you  
put in the preparation and in your attendance here.







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DR. SEGALL: Thank you very much.

THE CHAIRMAN: We will now take a  
short break and then go on with the Ontario Osteopathic  
Association brief.

---Short recess.



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DR. STOKES: Thank you very much.

THE CHAIRMAN: We will now take a

short break and then go on with the Ontario Catechism.

THE CHAIRMAN: We will now take a

short break and then go on with the Ontario Catechism.

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4 THE CHAIRMAN: The next brief is  
5 that of the Canadian Osteopathic Association and this  
6 will be Exhibit 252.

7 ---EXHIBIT NO. 252: Submission of the Canadian  
8 Osteopathic Association.

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10 S U B M I S S I O N O F  
11 CANADIAN OSTEOPATHIC ASSOCIATION

12 APPEARANCES:

13 DR. J. EDWIN WILSON

14 DR. ROBERT WETTLAUFER

15  
16 THE CHAIRMAN: Yes, Dr. Wilson?

17 DR. WILSON: Mr. Chairman, lady and  
18 gentlemen: I would like to introduce my partner, Dr.  
19 Robert Wettlaufer from Hamilton; I come from Barrie,  
20 Ontario. Is it your wish that I read through this brief  
21 in its entirety?

22 THE CHAIRMAN: No. What we would like  
23 you to do, if you will and if it is convenient for you to  
24 do it, is to summarize it as you may see fit and then  
25 come forward with any recommendations that you have.  
26 Whichever way is going to suit you best to make your  
27 presentation.

28 DR. WILSON: The preparation of this  
29 brief was undertaken by the Canadian Osteopathic Associa-  
30 tion to bring to the attention of the Royal Commission on  
Health Services pertinent facts concerning osteopathy:







Wilson 9365

- A. Training of osteopathic physicians.
- B. History of osteopathy.
- C. The attitude of the Canadian Osteopathic Association towards the national health plan.
- D. The appropriate role of osteopathic physicians in such a plan.

In our endeavour to do that we have dealt with each of these headings as we proceeded. In the first instance we have shown that the osteopathic physician receives the training that is comparable to that received by doctors of medicine. We have listed the various colleges where such training is available and it happens that all the colleges providing training are located in the United States. There are five such colleges.

The curriculum is listed showing the various subjects taught and these subjects are generally accepted as basic for the training of physicians and surgeons.

We did give a short history of osteopathy, how it began as a result of certain studies made by a medical doctor by the name of Dr. Still.

THE CHAIRMAN: Dr. Still was a medical doctor?

DR. WILSON: Yes, by 1874 because his discoveries were not accepted by his colleagues, he attempted to give his discoveries to his colleagues in medicine and his concepts were at such variance with the practices of the late 19th century that his offerings were not accepted. He established a college known as the





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American School of Osteopathy which accepted its first class in 1892. It is interesting to note a portion from the Charter that was given to that college at that time where it said in part:

"...to establish a college of osteopathy, the design of which is to improve our present system of surgery, obstetrics and the treatment of disease generally; to place the same on a more rational and scientific basis, to impart information to the medical profession and to grant and confer such degrees as are usually granted and conferred by reputable medical colleges..."

Thus, it will be seen that osteopathy has always been a complete school of medicine.

We attempted then to show, and we have shown here that the broad education and training of osteopathic physicians, while it is recognized in the United States, it has never been recognized to any great extent in the ten Provinces of the Dominion of Canada. Current graduates of osteopathic colleges, having spent a minimum of eight years in training to become physicians, hesitate to locate in a country that fails to allow them to practise as they have been trained. The various provincial legislatures differing in opinion from similar jurisdictions in the United States have seen fit to restrict the usefulness of physicians of the osteopathic school of medicine. As a result even our native sons are reluctant to return to practise in Canada as is illustrated by the fact that many ex-Canadians are now







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leaders in the osteopathic profession in the United States of America.

Then we went on to show that in the United States of America the recognition has taken place from both Federal and State levels of Government. By way of comparison, the neighbouring States of New York, Pennsylvania, Ohio, Indiana, Michigan and Maine, along with thirty-one other states, as well as the District of Columbia, grant osteopathic physicians the right to practise medicine in all of its branches. Many of these states have had such laws for more than fifty years and in no instance has the legislative body ever revoked the privileges granted osteopathic physicians.

The 84th Congress of the United States passed an amendment to the Army-Navy Public Health Service Medical Officer Procurement Act providing for the commissioning of doctors of osteopathy as medical officers in the Medical Corps of all branches of the armed forces on the same basis as doctors of medicine or doctors of dentistry.

The broad training of osteopathic physicians qualifies them to serve as high-calibre general practitioners. An example of this training is afforded by the Rural Clinic Program of the Kirksville College of Osteopathy and Surgery, Kirksville, Missouri. Senior student doctors under staff supervision serve the people in small rural communities within a service radius of the college. This fine educational experience equips these young doctors to meet the needs of rural medicine. The growing doctor shortage in Canada is particularly acute





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in rural areas. This growing need is to be relieved in part by encouraging more osteopathic surgeons to select Canada as their location.

Then, under Paragraph 23 we point out a resolution passed by the Canadian Osteopathic Association in 1945 and it is probably worthy of reiteration here. It says:

"WHEREAS the primary objective of the Association is the promotion and improvement of the public health; and

"WHEREAS, it recognizes the fact that certain portions of the population of Canada are unable to maintain themselves in good health; and

"WHEREAS it recognizes that a healthy people are a happy and economically stable people;

"IT THEREFORE APPROVES the principle of national health insurance and will endorse any workable plan which will assure complete and adequate health service for all income groups and which at the same time will preserve and protect the rights of the patient to a completely free choice of duly qualified physicians of any legalized school of practice without discrimination."

The conclusions to this brief are:

A, we have outlined the training received by osteopathic physicians.

B, we have reviewed a brief history of osteopathy.







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C, we have reported the attitude of the Canadian Osteopathic Association towards the national health plan.

D, we have described an appropriate role for osteopathic surgeons in such a plan.

We wish to concur with and support the briefs submitted by Provincial organizations. Our recommendation is that doctors of osteopathy should be used in all areas of national health services on the same professional basis as other doctors serving in the plan. This completes our brief.

THE CHAIRMAN: Thank you, Dr. Wilson. At the risk of summarizing too shortly and perhaps inadequately, do you say that (A) you are as well qualified as a medical practitioner?

DR. WILSON: Yes.

THE CHAIRMAN: And (B), that in any program of health services you should be allowed to participate and render such services as the public may ask of you by reason of your qualifications?

DR. WILSON: Yes.

THE CHAIRMAN: And you just fall in line with whatever system or program may be evolved to provide health services to the Canadian people?

DR. WILSON: That is exactly our thought, sir.

THE CHAIRMAN: If it is accepted, as you state in your brief, that the doctor of osteopathy is qualified in all phases of medical practice, why do you not drop the first qualification and just call yourselves physicians?





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DR. WILSON: Well, the practice of osteopathy is largely under the laws that have been enacted in various provinces. Probably I can answer that by reading from a section here where it states something about how the practice of osteopathy is across Canada; it varies from province to province. It is restricted in all of the Canadian provinces in varying degrees, three of the provinces, namely Prince Edward Island, Quebec and Newfoundland are without legislation regulating the practice of osteopathic medicine. New Brunswick has legislation.

THE CHAIRMAN: Does that mean that no one may practise in those provinces?

DR. WILSON: He might practise, but he would not have the protection of having a licence.

THE CHAIRMAN: Would he be considered to be practising medicine and, therefore, contravening the Medical Acts of those provinces?

DR. WILSON: I do not think so.

DR. WETFLAUER: I believe the situation in Quebec may partly explain. I believe -- of course, I do not live there, but the Province of Quebec does not have a specific legislative organization set up for osteopathic physicians, they are only allowed in by special decree, shall we say, or by special approval by the Provincial Department of Health. They do not come under any special Act. Now, this is by a special type of arrangement with that Department but just exactly how the mechanics of it are, I do not know.

COMMISSIONER McCUTCHEON: This is known







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in Quebec as a tolerance?

DR. WILSON: Yes, it is a tolerance.

DR. WETTLAUFER: In Ontario, of course, that situation is completely different as well as in most of the Western provinces, where a few of the provinces come under the College of Physicians and Surgeons.

COMMISSIONER McCUTCHEON: In two provinces?

DR. WETTLAUFER: In British Columbia and one more --- Alberta.





Wilson

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THE CHAIRMAN: What do you mean by that, come under the College?

DR. WILSON: They have a sort of a composite Board that gives the examinations to the new graduates.

THE CHAIRMAN: In osteopathy?

DR. WILSON: In osteopathy. People who wish to practise in osteopathy, and it is directly under the control of the Department of Health and the College of Physicians and Surgeons of that province.

COMMISSIONER McCUTCHEON: What is the situation in Ontario?

DR. WILSON: At the present time there is a Board of Directors of Osteopathy that regulates the practice of osteopathy in the Province of Ontario. This Board is appointed by the Lieutenant-Governor. They are under what is known as The Drugless Practitioners' Act. Prior to 1925 there was not such a thing as The Drugless Practitioners' Act, but this was brought into being in 1925, and since that time it has been the governing Act, limiting osteopathy to pretty much manipulate the procedures. In other words, it took away from the practitioners here the opportunity of doing more than just manipulative procedures.

COMMISSIONER BALTZAN: Gentlemen, I am looking here at your curriculum on page 2, and, of course, one sees a similarity for that of the M.D. course. Could you, in a word, tell me in what way you differ in practice seeing this similarity here to that? One knows about the curriculum of the regular course leading to the M.D.







Wilson

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In what way do you differ in practice?

DR. WILSON: Well now, the big difference is contained in some of these booklets that were appended to your briefs, which you don't happen to have with you.

THE CHAIRMAN: As you will appreciate, that was because of the change from the Ontario submission to the national one.

DR. WILSON: Which I hope you will have an opportunity to read, because they depict and show what we believe are osteopathic principles. Osteopathic principles are simply a knowledge and an evaluation of the nervous system, with its relation to the glandular system of the body, which are, as you know, the controlling factors of the body, and this glandular system and nervous system can be ---

COMMISSIONER BALTZAN: Excuse me, that was not my question, and those facts are contained in your appendix.

THE CHAIRMAN: We have it in the Canadian brief. What you are looking at is the Ontario brief.

COMMISSIONER BALTZAN: But we are in the right province.

DR. WETTLAUFER: I believe that the difference is very slight, and it is only an emphasis; the difference being mainly that the osteopathic School of Medicine emphasizes the mechanical or the muscular or skeletal pattern, or system of the body in relation to health and disease, not excluding the use of drugs, all forms of medication, nuclear medicine, surgery, obstetrics,





Wettlaufer

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all the other branches. It is a difference of emphasis, and that, I believe, is a very short summary of the difference between the two schools.

COMMISSIONER BALTZAN: You parallel what is now known as physiatrists, I believe; doctors of physical medicine?

DR. WETTLAUFER: No sir, actually we have a special Board in our Association in the States, which is also a physical medicine Board. In other words, a special group, and that is something else again, sir. I am sorry, I cannot answer fully that question because I really do not know enough about it.

COMMISSIONER BALTZAN: I will be glad to read into that a little further.

Has your Association approached universities as regards your status, and to be incorporated under the canopy of the university curriculum?

DR. WETTLAUFER: About six years ago the Canadian Osteopathic Association formed a Committee called the College Committee. It was in existence about three years, during which time they presented a report at each annual meeting as well as the semi-annual meeting.

In other words, two reports for the three years. They did a complete survey of what the cost would be to set up a separate School of Osteopathy in Canada. They also reviewed with educators in the different universities. I can think of two or three at the moment, Assumption College in Windsor, McMaster University in Hamilton. Offhand I cannot remember the others. They made a survey of the physical plant necessary,





Dr. W. J. L. ...

... the other ... it is a ... of the ... is a ... of the ... difference between the two ...

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Dr. W. J. L. ... have a special ... which is also a ... a special ... I am sorry, I ... I really do not know ...

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Wettlaufer

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the staffing, the equipment and the potential necessary to handle a good number of students graduating from one, two, three, four years, until finally, at the fourth year of operation, they would have a complete school.

That group was disbanded about three years ago and the Board of Governors of the proposed college was then - it came into being, I believe, about 1959. That Board is made up at the present time of osteopathic physicians.

There is provision on the Board for four or five lay personnel. This is a group which is not responsible to the Canadian Association. They have complete autonomy on their own. They were originally started by the Association but the Association felt that as an Association they should not have control over that group. That is where the situation stands at the moment. They are still investigating and having regular meetings about four or five a year. The objective, of course, is to start a College of Osteopathy, either with a university or on their own, depending upon the financial arrangements.

COMMISSIONER BALTZAN: Have you a written report on the negotiations? Is it available, because it would help us a lot, rather than discussing it here.

DR. WETTLAUFER: No, I don't, but I am quite sure we will be able to supply you with one.

THE CHAIRMAN: The doctor's question was, is there one available, and could we have it?

DR. WILSON: Yes, we can supply you with





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Wilson

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one.

THE CHAIRMAN: If you would be good enough to send it to our Secretary?

DR. WILSON: Yes, sir.

THE CHAIRMAN: Thank you very much, gentlemen. You may rest assured that the documents which were appended to your Canadian brief will have the consideration of the Commissioners in due course, along with the representations made here today.

DR. WILSON: Thank you.





one.

THE CHAIRMAN: If you would be good

enough to read it to our assembly.

MR. WILSON: Yes, sir.

THE CHAIRMAN: Thank you very much.

Gentlemen, you may rest assured that the documents which were appended to your Canadian brief will have the consideration of the Commissioners in due course, along with the representations made here today.

MR. WILSON: Thank you.



DR. JOBIN: Mr. Chairman, the next submission will be made by the Canadian Academy of Allergy and this will be Exhibit No. 253, and Dr. FitzGerald will lead the delegation. Dr. FitzGerald, will you please introduce your delegation?

--- EXHIBIT NO. 253: Submission of the Canadian Academy of Allergy.

SUBMISSION OF THE CANADIAN ACADEMY OF ALLERGY

Appearances: Dr. J. FitzGerald  
Dr. J.H. Toogood  
Dr. H.L. Bacal  
Dr. Jacques Leger

DR. FITZGERALD: Allergy is a very recent (50 years) entity in clinical medicine.

The incidence of clinically significant allergic disease is 7-10% in the general population. Of this fraction, morbidity may be only moderate (e.g. "hay fever" = 2.4%, but may be extreme (e.g. asthma = 2.2%); in addition, sudden death, often avoidable, may occur (e.g. allergic shock and death from drug sensitivity and less frequently from insect bites).

Present health services relating to diagnosis and treatment of allergic disease are inadequate quantitatively, and to a lesser extent, qualitatively.

Progress in correction of deficiencies of health services in this field has been slow due to:-

- (a) lack of trained physicians and thus
- (b) inadequate facilities for undergraduate and continuing graduate teaching, and research.



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 Allergy and this will be subject to 1953, and Dr. Fitz-  
 Gerald will lead the delegation. Dr. FitzGerald, who  
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SUBMISSION OF THE CANADIAN ACADEMY OF ALLERGY

Agencies: Dr. J. FitzGerald  
 Dr. J. H. Thompson  
 Dr. H. L. Macdonald  
 Dr. J. Macdonald

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Present health services relating to

diagnosis and treatment of allergic disease are inadequate  
 quantitatively, and to a lesser extent, qualitatively.

Programs and organization of research

at health services in this field has been slow in the

- (a) Lack of trained specialists and thus
- (b) inadequate facilities for studies

graduate and continuing education for health



FitzGerald

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(c) inadequate financial support for  
(a) and (b)

(d) only recent (1945) formation of a  
national clinical society for inter-  
change of ideas, and improvement of  
the standard of practice of clinical  
allergy.

(e) only recent (post World War II)  
gradual increase in the number of  
qualified teachers available to medical  
schools, for

(f) establishment of teaching programs  
in medical schools, both didactic and  
clinical, with improving collaboration  
between faculty departments for teaching  
purposes (e.g. medicine, pathology,  
immunology, therapeutics, paediatrics,  
and preventive medicine).

#### Requirements

(a) expanded undergraduate and continuing  
graduate teaching programs in most  
medical schools.

(b) increased financial support for  
teaching and research facilities.

(c) standardization of requirements  
for teaching positions, and the practice  
of clinical allergy, to improve the  
quality of practice available through  
health services, whether in hospital,  
clinic, office or the home.





Page 10

(c) inadequate financial support for  
(1) and (2)  
(d) only research (1945) formation of  
national clinical society to monitor  
change of ideas, and improvement of  
the standard of practice of clinical

(e) only research (post World War II)  
gradual increase in the number of  
qualified teachers available to primary  
schools, for

(f) establishment of teaching programs  
in medical schools, both clinical and  
clinical, with improving collaboration  
between faculty departments for teaching  
subjects (e.g., medicine, pathology,  
laboratory, therapeutics, pediatrics,

Recommendations

(1) expanded undergraduate and continuing  
graduate teaching programs in post

(2) increased financial support for  
teaching and research facilities.

(3) greater liaison of universities  
for teaching hospitals, and the practice  
of clinical medicine, to improve the  
quality of instruction available to train  
health services, whether in hospital,  
clinical, either in the home.



Leger

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THE CHAIRMAN: Thank you, Dr. FitzGerald. Now, have any of you gentlemen also present anything to add at this time by way of observation or illustration of what has been said?

DR. LEGER: I have nothing to add to the brief; I just would like to make one remark. I guess that we can say that we have two main purposes in presenting this brief. First, from the line that allergy is now known in a lot broader sense than it was some years ago.

THE CHAIRMAN: You say 7 to 10%. Is that pretty well uniform across the country?

DR. LEGER: It is pretty well uniform across the continent, the same in the United States as in Canada, and as it is known in a much broader sense than before, it depends largely on development and research.

DR. BACAL: We know that the tendency to develop allergic diseases is a hereditary factor. The disease is not transmitted, but the hereditary tendency is transmitted and I think that greater educative measures, both to the lay and the practitioners, should be instituted. For instance, if you have a potentially allergic child, that is a child with one or both parents allergic, if one parent is allergic maybe 10 to 15% of the offspring will be allergic, but if both parents are allergic, maybe as high as 40% of the offspring will be allergic so if we can institute preventive measures, even during the time of pregnancy and after pregnancy, it is very important.





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4 Actually, we facetiously tell the  
5 students sometimes that if they are allergic and are  
6 going to marry an allergic individual, to make sure that  
7 they are financially well off.  
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4 THE CHAIRMAN: I suppose that brings  
5 us down to a very relevant and down to earth question:  
6 What about the treatment of allergies? When a person  
7 has an allergy he has to have his treatment.

8 DR. FITZGERALD: I think one has to  
9 define the type of allergy. One cause for confusion is  
10 almost everybody has a symptom which is labelled an  
11 allergy. This causes feelings of insecurity in which  
12 one often hears he is allergic to his mother-in-law or  
13 their job. Scientifically we restrict the word allergy  
14 to the reaction that occurs -- I can give you a scientific  
15 example, the type of allergy where immunization procedure  
16 is required for treatment, indeed repeated procedures  
17 are required to immunize the patient, not one such as  
18 with the virus infections, polio. These are needed  
19 much oftener. I don't think I need elaborate on that.  
20 On the other hand the profession are well aware of the  
21 short-comings of this type of treatment as far as its  
22 usefulness. Perhaps this is an intermural problem even  
23 in the teaching schools to see this eliminated in the  
24 future. It is to this point that our last paragraph is  
25 pertinent.

26 THE CHAIRMAN: It may be allergies, in  
27 the true sense you have been talking about, are illnesses.

28 DR. FITZGERALD: That is right, I  
29 think there are. There again it is difficult to define  
30 such a variety of things, the hay-fever reaction, the  
sudden death from the injection of penicillin, the  
uncomfortable, but not fatal shock reaction from the bite  
of an insect, and probably rheumatic fever following



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THE CHAIRMAN: It may be allergies in the true sense you have been talking about are illnesses.

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Fitzgerald

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4 steptococcal sore throat. There are allergy components  
5 in various things.

6 This is not confined to medical people,  
7 of course, but patients because we have to deal with  
8 immunological, pathological as well as clinical. Again  
9 we come back to this matter of immune mechanism that  
10 are poorly understood today as Dr. Lesage indicated.  
11 This requires a lot of clarification before they will  
12 have clinical usefulness.

13 THE CHAIRMAN: What I am trying to  
14 see is how it may be adopted into the pattern of pre-  
15 paid medical care programs?

16 DR. FITZGERALD: Yes, sir. I think it  
17 is agreed almost unanimously that a man who is acting  
18 as a teacher or a consultant in this field of clinical  
19 immunology must have the basic education in medicine  
20 of a post-graduate level. He must be certified in  
21 internal medicine or paediatrics or have his Fellowship  
22 in the Royal College of Physicians and Surgeons.  
23 Anything else is inadequate. I think while this has  
24 wrought some hardship on senior members of the profession  
25 in recent years, I think for the welfare of the patients  
26 in the future we must insist on this standard of quality.  
27 I think it belongs to those two departments to supervise  
28 all teaching and all diagnosis and treatment.

29 THE CHAIRMAN: So there would be  
30 assistance require in both fields?

DR. FITZGERALD: That is right.

THE CHAIRMAN: I am coming down now  
to the man on the street who is subject to an allergy  
and he is required to go and see a physician periodically



in various things.

This is not confined to medical people  
of course, but business people we have to deal with  
human beings, pathological as well as clinical. Again  
we come back to this matter of human mechanism that  
we only understood today as Dr. Leese indicated.  
This requires a lot of clarification before then will

THE CHAIRMAN: What I am trying to  
say is now it may be added into the pattern of  
said medical care programs?

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as a researcher or a consultant in this field of clinical  
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Another bias is independent. I think while this has  
brought some harmony on session members of the profession  
in recent years, I think for the welfare of the patients  
in the future we must insist on this standard of quality.  
I think it is better to have two departments to supervise  
all research and all standards and treatment.

THE CHAIRMAN: So there would be  
separate departments in each of these  
of the field, that is correct.

THE CHAIRMAN: The answer was we subject to an officer  
of the field to be a physician or biologically



Fitzgerald

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3 to get, as they say "I am going to get my shot today".

4 DR. FITZGERALD: Yes sir.

5 THE CHAIRMAN: That costs him money.  
6 Is that type of illness covered by the present plan?

7 DR. FITZGERALD: Yes sir.

8 THE CHAIRMAN: Prepaid medical plan  
9 like P.S.I.?

10 DR. FITZGERALD: Yes sir, the  
11 immunization injection is listed in the O.M.A. schedule  
12 of fees under three separate headings, which causes  
13 some confusion in our minds. I am not qualified to  
14 speak on that point. I think under one of those headings  
15 I am sure immunization injections would be covered. As  
16 far as our understanding is concerned I think the man  
17 on the street would be free to go to his practitioner  
18 for an immunization injection. His doctor may charge  
19 him for the material in those injections just as he  
20 would for liver extract for pernicious anemia.

21 THE CHAIRMAN: Doctor Leger, is this  
22 one of the things covered on the Les Services des Sante in  
23 Quebec?

24 DR. LEGER: Yes, Mr. Chairman.

25 THE CHAIRMAN: I know that D.V.A. has  
26 provided that service for all army personnel and for those  
27 who qualify for D.V.A. benefits, because some people  
28 seem to think that is about the only place they can really  
29 get some sort of protection against paying for this  
30 service, even where they have the medical coverage, the  
prepayment coverage.

DR. LEGER: We feel there is no problem



to let, as they are, I am going to pay for it, I am going to

the type of illness covered by the present policy

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Leger

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as far as this is concerned and we consider ourselves as physicians or technicians, and our consultants are very well covered by any prepaid medical plan, and immunization is very well covered too.

THE CHAIRMAN: As long as that condition continues, as long as that remains recognized as an illness then your attitude towards prepayment plans is it is the same as with regard to other illnesses?

DR. LEGER: That is correct, sir.

DR. BACAL: But we are primarily concerned with teaching and research so that facilities for the future are enhanced in relation to teaching and research. Grant in all Canada perhaps about \$200,000.00 is spent a year in research and the moneys obtained are from private sources, actual contributions, pharmaceutical houses and the maximum amount of money I think comes from the United States.

THE CHAIRMAN: There is no government support for your research?

DR. BACAL: Very little.

DR. FITZGERALD: The Medical Research Council have been very generous in their support within their budget, but the work in the five institutions as listed in Appendix 4 -- there are five teaching institutions in Canada where any attempted research work is going on, these institutions have pretty well resorted to the United States granting agencies for their funds. I am sure this is not unique among other special disciplines.





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THE CHAIRMAN: That is my government  
 support for your work.  
 THE CHAIRMAN: Very little.

Donnell have been very generous in their support with  
 their budget, but the work in the field is not  
 as listed in Appendix A -- there are five research  
 institutions in Canada where the research is carried  
 out. In going on, these facilities are being built  
 reported to the United States government agencies for  
 their funds. I am sure this is not only a very good  
 special disability.



FitzGerald

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THE CHAIRMAN: Dr. Baltzan.

COMMISSIONER BALTZAN: Gentlemen, reading over your brief it seems to me that most of the points you raise here are actually intimately related either to the profession or academics. Am I right in that?

DR. FITZGERALD: That is right.

COMMISSIONER BALTZAN: Coming back to one point that you raised that seems to stand out, your lack of recognition by the Royal College as a separate entity of the specialty.

DR. FITZGERALD: Yes, sir, that is in the addendum. I think that is put in the addendum. If I could just read that one:

"This information is not presented here as a problem, the correction of which should be considered to lie within the scope of governmental legislation. Rather, it is presented to the Commission as background information. It illustrates in a specific way, an area where suboptimal (or even inadequate) health services can only be improved by action from within the profession itself; an area where, in the absence of such action by the profession, no conceivable form of government intervention could achieve the same ends; and an area where joint action by the authorizing bodies within the profession along with government (in the nature of paragraphs IV(c) and V(b) above) could achieve more than either one alone."

We believe, sir, that we must police our own problems.





Fitzgerald

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4 COMMISSIONER BALTZAN: It still boils  
5 down to that which I said in the beginning?

6 DR. FITZGERALD: Yes sir.

7 COMMISSIONER BALTZAN: Professional  
8 and academic?

9 DR. FITZGERALD: Yes sir.

10 COMMISSIONER BALTZAN: So we see in  
11 your requirements and recommendations, under graduate  
12 teaching, post-graduate training and so on. What are  
13 your specific recommendations?

14 DR. FITZGERALD: I think, sir, they will  
15 be encouraged in the teaching programs of individual  
16 medical schools. I am sure that the deans of individual  
17 faculties have these problems in mind in their  
18 submissions at a later date. We are a very small part  
19 of the whole.

20 COMMISSIONER BALTZAN: Now that you  
21 have your own national society you are able to meet  
22 with the Deans, meet with the faculties and arrange  
23 these things?

24 DR. FITZGERALD: Yes sir. The Deans  
25 of the schools to which I eluded, the five that presently  
26 have programs, there is no problem in their minds of  
27 extending the short-comings both in clinical practice  
28 and in quality of practice. They accept the cause of  
29 short-comings in the past. I am sure that to date  
30 adequate personnel are available, even to other teaching  
schools to meet some of these problems in their teaching  
programs. I am sure this will be a long term program.

COMMISSIONER BALTZAN: So your only





CONFIDENTIAL - SECURITY INFORMATION  
 town to that effect. I will be the person to  
 Mr. [Name] [Address]  
 CONFIDENTIAL - SECURITY INFORMATION

and academic?

CONFIDENTIAL - SECURITY INFORMATION so we are in  
 your requirements and recommendations, which elements  
 teaching, post-graduate, training and so on. What are  
 your specific recommendations?

MR. [Name]: I think, yes, I think  
 as encouraged in the teaching program of individual  
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 facilities have these problems in mind in their  
 subdivisions at a larger level. We are a very small part  
 of the whole.

CONFIDENTIAL - SECURITY INFORMATION How can you  
 have your own national academy, for example, to meet  
 with the needs, meet with the facilities and arrange  
 these things?

MR. [Name]: As a matter of fact, the needs  
 of the schools to which I referred, the idea that we  
 have programs, there is no program in their school of  
 extending the short-course, or in general, I question  
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 programs. I am sure that will be a long time before  
 [Name] [Address]



Fitzgerald

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specific recommendation is to try and get a little more money so you will be able to do things along your line?

DR. FITZGERALD: Yes sir. If I could just refer to what Dr. Armstrong said in an earlier brief this afternoon, the technologic help and equipment -- in immunology today there are such vast strides being made in the field of clinical immunology that we require more at the Ph.D. level, individuals with immunological, chemical, biochemical backgrounds. To find those people has been difficult. These people with the backgrounds of research and clinical application -- we feel this should be included in the hospital budget. This is what we hope for the future. Right now some of our research funds do support such people, but these career scientists want more security than a two or three-year grant. We feel that this will become more rapid in a few years, this lack of education, basic training, research.

THE CHAIRMAN: It is still a matter of your negotiations with faculties, universities, et cetera.

DR. FITZGERALD: Now, sir, I speak for the University of Toronto at this time; we have been very fortunate in our universities and having people, the support of the deans and professors of medicine encouraging this expansion in the teaching of clinical immunology. I know it is true with McGill University, at London, at the Western University, three or four of the large teaching centres. I think most of these universities reach out and take the men from the other



specific recommendation is to try and get a little more money so you will be able to do things along your line.

DR. FITZPATRICK: Yes, sure. If I could just refer to what Dr. Armstrong said to an earlier brief this afternoon, the technological help and cooperation -- in immunology today there are such vast strides being made in the field of clinical immunology that we need more at the M.D. level, individuals with immunologic, chemical, biochemical backgrounds. To find those people has been difficult. These people with the backgrounds of research and clinical application -- we feel this should be included in the hospital budget. This is what we hope for the future. Right now some of our research funds do support such people, but these career scientists want more security than a two or three-year grant. We feel that this will become more rapid in a few years, this lack of education, basic training.

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centres, snap them up.

THE CHAIRMAN: They reach out and take them from the other universities?

DR. FITZGERALD: Yes sir, I am afraid in our own way we do the same thing to be truthful. The Ph.D's, we reach out to Buffalo and see if we can get one of their men to come and work for us.

THE CHAIRMAN: Professor Firestone.

COMMISSIONER FIRESTONE: Dr. FitzGerald, if I may follow that for a moment the answers that you have given to our Chairman in reply to the application of the prepayment principle to treatment connected with medical allergies, do I understand that your Association feel that if a medical care plan or plans are developed for Canada that medical care services concerning allergies should be covered in such plan or plans?

DR. FITZGERALD: May I ask Dr. Toogood to answer. He is president of the Canadian Academy.

DR. TOOGOOD: Sir, in answer to that question, we feel that the system of paying for services rendered for allergic illnesses should be exactly the same as with all other illnesses, both physical and mental. If the system in practice is a voluntary health insurance scheme it is acceptable to us insofar as it is acceptable to the parent body with which we are affiliated, that is the Canadian Medical Association. The chief point that we wish to make in the brief, and I think it has been very well made by my colleagues, is the fact that our major problems in this small specialty are not so much those of distribution and







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4 availability of the service, of the special service  
5 across the country, but the development of the basic  
6 resources, academic resource which will allow us to  
7 increase our personnel. This is the major problem,  
8 not so much the actual system of payment for the service  
9 that exist at the present time.

10 COMMISSIONER FIRESTONE: We really  
11 are looking ahead to the future, sir, and I presume  
12 we want to relate the demand for such services to the  
13 supply of physicians able to render such services,  
14 and therefore, if we are talking of a more comprehensive  
15 plan, I presume a prepaid plan, I presume that the demands  
16 for such services will increase it is to meet such demands  
17 that you in the profession feel that you need more  
18 specialists in that field.

19 THE CHAIRMAN: If I understood your  
20 correctly they need more teachers?

21 DR. TOOGOOD: Correct, sir, if I may  
22 say so.

23 THE CHAIRMAN: This is the general  
24 practitioner wholly?

25 -

26 -





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FitzGerald 9390

DR. FITZGERALD: That has been said, Mr. Chairman. I am sorry, if I may interrupt. I think Dr. Toogood might have extended his statement. The general practitioner probably treats 95% of these cases and will continue to do so.

THE CHAIRMAN: You are not sending out specialists into the countryside?

DR. FITZGERALD: No, sir. On the contrary, we are trying to do just the opposite.

COMMISSIONER FIRESTONE: Would you feel that in order to provide such medical services, would you feel that you wanted to continue to rely on the general practitioner to provide such service or would you also feel that there would be a greater need and demand for specialists in the field?

DR. FITZGERALD: I think I can answer that, sir, by saying that the practitioner in a centre where there are consultants available will readily use his services and he is often busy and wants an opinion and advice about treatment as quickly as he can get it for the patient's best interest and qualitatively, naturally, he wants to get the best result he can get.

While he will probably treat some patients without consultation, he will send a great many of them, in this City at least, for consultation and opinion, following which the patient is, of course, returned to his family physician with a covering report and recommendations for treatment and unless something goes awry, or the result is not optimal, we often hear nothing further of that patient.







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COMMISSIONER FIRESTONE: I am just trying to understand the implications of a comprehensive medical care plan which would include treatment for allergy diseases. As I understand it, such a prepaid plan which would cover more people than have been covered so far, might increase the demand for such services. The demand for such services will be, in the first place, addressed to the medical practitioner. The medical practitioner, in turn in difficult cases will desire to have some consultation.

Therefore, if I understand you correctly, a comprehensive prepaid plan will increase the demand for such services, both from the medical practitioner and from the specialist. Am I correct?

DR. FITZGERALD: I would think so, sir, yes.

COMMISSIONER FIRESTONE: Your requirements are for a larger number of medical practitioners trained in the field, plus a number of specialists, is that correct?

DR. FITZGERALD: I think that is a fair statement, yes.

COMMISSIONER FIRESTONE: Now, sir, there was one other bit of a problem that may be encountered. Would you be concerned about the possibility of abuses of such a medical care plan which would include the treatment of allergy diseases, in the first instance by the general practitioner?

DR. FITZGERALD: I think the only reason to believe that abuses have occurred in the past



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DR. FITZGERALD: I think the only  
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and might occur in the future, would be if a specific technique, such as doing allergy skin tests, were allowed at an excessively high rate by the fee schedule, and applied in any given Province.

This might lead to abuses. I think this is a fair statement. On the other hand, if a realistic charge is put on such service, I think of comparable things such as cardiograms for heart patients, I don't think the allergy skin testing should be out of line with such a procedure.

I think this would discourage abuses, to use a word I think is really not applicable frequently nowadays.

On the other hand, in the past when allergy was a relatively new clinical science -- that is not long ago -- there was a fee schedule that allowed so much per test, and still obtains in some fee schedules and this might encourage some individuals to do a test that in other peoples' opinion might not be justified. However, this is a matter of clinical judgment and I think we can quarrel about the importance of it. If a particular maximum is put on a particular service of this type, I don't think abuses would occur, no.

COMMISSIONER FIRESTONE: I don't quite understand what you mean by maximum. Would you say that the plan would provide a maximum number of treatments or maximum amount of money paid per treatment? What do you mean?

DR. FITZGERALD: I think there are two points, sir. I think the first one is diagnostic







FitzGerald 9393

tests, which is the first point of abuse. I think that can be dealt with by putting a maximum on services rendered; fee for service type of remuneration.

COMMISSIONER FIRESTONE: The first, therefore, is ----

DR. FITZGERALD : Diagnostic.

COMMISSIONER FIRESTONE: Maximum amount for the treatment?

DR. FITZGERALD: No, sir, for diagnostic tests. I agree with Dr. Toogood, I see no reason why this should be any different from any treatment procedure where a hypodermic injection is required.

COMMISSIONER FIRESTONE: Have you also some comments on the maximum number or are you solely concerned with the maximum amount?

DR. FITZGERALD: I don't think you can put a maximum number on this, because in our clinic, for instance, a single patient would require an injection every two weeks and infants and children often start at once a week and go for as long as a year. In adults this number is not required to get optimal treatment results, so I don't think you can really restrict it in any fee schedule I can imagine.

COMMISSIONER FIRESTONE: Would you feel that the treatment that would be covered under such a plan should include all such service which in the opinion of the medical profession is considered necessary to achieve a cure or at least, arrest the condition?

DR. FITZGERALD: Yes, sir.

COMMISSIONER FIRESTONE: Is that by



...is the first point of view. I think that  
 can be dealt with in terms of a number of services  
 not only for the service type of organization

Therefore, is ---

Dr. [Name] : [Name]  
 [Name] : [Name]  
 for the treatment

Dr. [Name] : [Name]  
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 because where a hydrostatic infection is present.

Commissioner [Name] : Have you  
 also some comments on the maximum number of the  
 occurred with the maximum amount?

Dr. [Name] : I don't think you can  
 put a maximum number on this, because in our clinical  
 experience, a single case would require an infection  
 every two weeks and it would be difficult to state in  
 one's mind and to be sure as a result, in addition this  
 number is not required to be a maximum treatment course,  
 so I don't think you can really say it in any case  
 whether I can find out

Commissioner [Name] : [Name]  
 that the treatment is to be in a covered area and a  
 then should involve the same as what is in the  
 the medical, [Name] is a [Name] and [Name]  
 for the [Name] of [Name], [Name] is [Name]  
 Dr. [Name] : [Name]  
 [Name] : [Name]



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judgment?

DR. FITZGERALD: Yes, sir.

COMMISSIONER FIRESTONE: And that if there is any limitation, it would be on the amount of money that is paid for the service?

DR. FITZGERALD: For the diagnostic service, yes. I feel that is right.

COMMISSIONER FIRESTONE: You have tests. There may be numerous tests. Would you apply that restriction to tests as well?

DR. FITZGERALD: Yes, sir, I think this is where I mean a maximum should apply.

COMMISSIONER FIRESTONE: Now, therefore, if the physician wishes to charge a higher fee than would be covered under this fee schedule and that maximum, he would be then charging the patient for the difference?

DR. FITZGERALD: Presumably, yes.

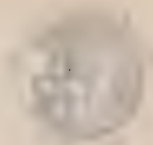
COMMISSIONER FIRESTONE: Unless he is willing to take the maximum as the acceptable fee.

DR. FITZGERALD: I think the majority of specialists, if we use this word, qualified consultants in this field today, are quite satisfied with the Ontario Medical Association schedule of fees as they exist regarding skin testing.

COMMISSIONER FIRESTONE: How is the position in Quebec, Dr. Leger? Or have you any other general comments on the question we have just been discussing?

DR. LEGER: We would be satisfied with a similar plan. There is no doubt about that. We have





Q. Now, is that correct?

A. Yes, that is correct.

Q. Now, if there is any limitation, it would be of the amount of

money that is paid for the services?

A. Yes, that is correct.

Q. Now, is that correct?

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money that is paid for the services?

A. Yes, that is correct.

Q. Now, is that correct?

A. Yes, that is correct.



Leger 9395

exactly the same views.

DR. BACAL: Actually our skin testing procedure is --- what we are concerned with in seeing a new patient is a clinical procedure in that it isn't just a matter of doing skin tests. It's a matter of seeing the patient, taking a complete history, doing a physical examination and then doing the skin test as a clinical procedure to prove or disprove the diagnosis and to augment and finalize the diagnosis, so just doing skin testing alone is not the important thing; it's just as an augmentation to the history and physical examination, when necessary.

Sometimes skin tests are not even necessary. If a patient comes in and says, "Doctor, when my child plays with a cat, he gets asthma" and they want to be tested, that is ridiculous. The child comes in contact with the cat and gets asthma, you get rid of the cat and the child doesn't get asthma, so no tests are necessary.

DR. FITZGERALD: No consultant is needed either.

COMMISSIONER FIRESTONE: Thank you for those comments. Dr. FitzGerald, may I turn now to Paragraph IV, sub-paragraph C on Page 4 of your brief, where you suggest that financial support should, in the long-run, be forthcoming from grants; and I quote...  
by grants from more permanent agencies such as university medical schools, and the Medical Research Council (already making a sizeable contribution)".

How much money is presently made

exactly the same views.

Dr. HUGHES: I have one question. The procedure is -- what we are concerned with in testing a new patient is a clinical procedure in that it is just a matter of seeing the patient, taking a complete history, doing a physical examination and then doing the skin test as a clinical procedure to prove or disprove the diagnosis and to suggest and limit the diagnosis. We just do skin testing here in the laboratory and that's just as an indication to the physician and not as a procedure when necessary.

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4 available by the Medical Research Council for research  
5 in your specialized field?

6 DR. FitzGERALD: I haven't got the  
7 exact figure, sir.

8 COMMISSIONER FIRESTONE: Approximately?

9 DR. FitzGERALD: I would think about  
10 \$50,000.00 per annum at the moment out of a total of  
11 about \$200,000.00 from all agencies.

12 COMMISSIONER FIRESTONE: And you would  
13 feel that the \$50,000.00, more or less, is inadequate and  
14 you would feel that a considerably larger amount should be  
15 made available?

16 DR. FitzGERALD: I agree, yes, sir.

17 COMMISSIONER FIRESTONE: Now, what  
18 would your recommendation be of an amount that the  
19 Federal Government should make available for research on  
20 an annual basis?

21 DR. FitzGERALD: I think that cannot  
22 be answered with one figure, sir, because of, again, the  
23 variation from school to school of degree of development  
24 of the Departments of Clinical Allergy.

25 I think at McGill University, for  
26 instance, an almost absolute figure could be struck with  
27 some ease by the Dean of Medicine.

28 I think at the University of Toronto  
29 it would be less easily available, and I would think this  
30 applies at Western Ontario.

If you went to the University of  
British Columbia where this year they have, for the first  
time, a man with his fellowship in Medicine on the







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department's medical staff, I would think they have no idea how much money they are going to require at the moment, because of lack of personnel; the availability of all levels of personnel. I am sorry, this is a very indirect response.

COMMISSIONER FIRESTONE: You see, Dr. FitzGerald, you are suggesting to the Royal Commission that we ought to recommend to the Federal Government to spend more money, or make more money available on research in the field of allergy, which sounds to us as a very reasonable request, and we are assured by you that this money would be used usefully and constructively in the interests of medicine, to further your knowledge on how to deal with problems in this field.

If we do not get a suggestion from you as to how much more money the Federal Government should spend, where should we go for such advice?

DR. FITZGERALD: I think, sir, if I may be colloquial for a moment, I am sorry I cannot answer on a national level. I feel number three and four will deal with the faculty of medicine, also the teaching hospital. In the budgets recommended by Dean Hamilton, Professor Whiteman there will be financial support for training these experts in the basic sciences, the budgets to which I alluded earlier.

I am sorry I cannot go beyond that point.

DR. TOOGOOD: Could I speak to that point? I think, Mr. Chairman, that approximately of the \$200,000.00 that is spent within the past year for allergy





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research in Canada that more than half of that amount comes from the United States and that a sizeable proportion of the remainder comes from private donations. That one could take that \$200,000.00 figure alone, and I suggest that it would be more reasonable if that whole amount was made available from Canadian Governmental sources, would render us less dependent on outside sources and charitable individual donations.

DR. BACAL: May I add it should be worked on a sliding scale. As the faculties related to teaching of allergies increase, that there should be a sliding scale and increase the grants from, say, \$200,000.00 to higher amounts as the years pass by.

COMMISSIONER FIRESTONE: You want such grants which are usually given to the Department of Medicine to be earmarked for allergy, or you want to have your faculties allocate the money that you require in your activities, or in your department?

DR. FITZGERALD: I am sorry, sir, I am not quite sure of the point.

COMMISSIONER FIRESTONE: You are asking for grants to be made. Do you want these grants to be earmarked for allergy or to be collectively designated, say, for the Department of Medicine?

DR. FITZGERALD: I would think the departmental grants, because it certainly was the responsibility of the individual investigator and teacher to make his needs known. Should be our own departmental head.

COMMISSIONER FIRESTONE: Do I understand







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these research grants will be made available to be used for research in the field of allergy?

DR. FITZGERALD: Yes, sir.

COMMISSIONER FIRESTONE: Not for other subjects?

DR. FITZGERALD: Not for other subjects. Specifically be made available for this purpose. We will make our wishes clear to the professor of Medicine and the Dean.

COMMISSIONER FIRESTONE: The suggestion has been made that a Federal grant might initially be raised from \$50,000.00, more or less, to at least \$200,000.00 and that the later stage, over the years as your resources and facilities and manpower increase, be increased further. Is that the point that your Association would support?

DR. FITZGERALD: Yes, sir.

COMMISSIONER FIRESTONE: All right, can we now turn to Page 6, V, Sub-paragraph B. You say, sir, in the last sentence of that paragraph that specialists in the field of allergy are in short supply, and I take it that is what you mean by the words "such personnel". If not, I stand to be corrected, and then I quote "...are in short supply at present, but presumably as in other technical areas this shortage will be corrected if an overall improvement of health services develops." Would you please explain to us what you mean by the phrase "overall improvement of health services."



10-11-44

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Dr. Friedman, New York, New York  
COMMISSIONER OF HEALTH

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increased further. Is that the point that your association  
wishes to suggest?

and we now turn to Page 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000



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4 DR. FitzGERALD: Availability of more  
5 funds.

6 COMMISSIONER FIRESTONE: Availability  
7 of more funds but covering health services on a compre-  
8 hensive basis including the treatment of diseases of  
9 allergy?

10 DR. FitzGERALD: No, I am just referring  
11 back to the university level and the need for training  
12 more teachers and research workers. That is where these  
13 funds would be applied; they are not applied at the  
14 treatment level at all.

15 COMMISSIONER FIRESTONE: If that is the  
16 case could you explain to me the meaning of the phrase  
17 "overall improvement of health services"? To me, health  
18 services are services rendered to treat people. Perhaps  
19 I do not understand the meaning of the phrase and that is  
20 what I would like you to explain.

21 DR. FitzGERALD: I think it must be  
22 interpreted as an indirect result of having improved  
23 techniques available that we will improve the standard  
24 of teaching and practice and that, in turn, will result  
25 in a qualitative improvement in treatment of patients in  
26 general practice.

27 COMMISSIONER FIRESTONE: Does the phrase  
28 "health services" refer to treatment?

29 DR. FitzGERALD: Yes, sir.

30 COMMISSIONER FIRESTONE: And you expect  
an overall improvement of such health services to take  
place as a result of what?

DR. FitzGERALD: With improved teaching







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and research programs in the teaching hospitals which will increase the supply of properly trained specialists and also properly trained practitioners.

COMMISSIONER FIRESTONE: Well then, you are saying, and if I paraphrase your wording, that such persons are in short supply and the solution would be found if the supply of such personnel were increased because you are relating the improvement of health services to an increase in the supply so you are saying the short supply will be resolved when the supply increases? Is that it?

DR. FITZGERALD: Yes, I think it is both a quantitative and qualitative improvement.

DR. TOOGOOD: It seems to me you are talking at cross-purposes. I think the point you are wanting to make is the point we would all echo and that is that we need more allergists, better allergists and the way to get them is to improve the methods of teaching and schools teaching allergists, as any other specialty, depends primarily on the activity of the academic and research world; that the best way to get more allergists and better allergists and recruit them into the health services to apply the effort to the university. We are using the term "health services" in a slightly more limited and different fashion than I gather Commissioner Firestone is.

COMMISSIONER FIRESTONE: I am not using it in any sense, I am trying to find out what you mean.

DR. TOOGOOD: Does that help or does that help to confuse the issue?



and the other programs in the learning community. They  
 are looking at the supply of people and the special  
 and also properly trained professionals.  
 community. They are well known, as  
 are saying, and if I paraphrase your words, they are  
 persons are in short supply and the solution would be  
 found if the supply of such personnel were increased.  
 because you are relating the improvement in health  
 services to an increase in the supply so you are saying  
 the short supply will be resolved when the supply  
 increases? Is that it?

Dr. [Name]: Yes, I think it is.  
 both a quantitative and qualitative improvement.  
 Dr. [Name]: It seems to me you are  
 talking at cross-purposes. I think the point you are  
 wanting to make is the point we would all agree and that  
 is that we need more physicians, better aologists and  
 the way to get them is to improve the method of teaching  
 and schools teaching aologists, as you call them, and  
 doctors particularly on the part of the students who  
 need it; that the best way to get more aologists  
 and better aologists and aologists then into the health  
 services to supply the effort of the university, it is  
 using the term "health services" in a slightly more  
 limited and different fashion than I gather you mean.  
 I disagree.

Dr. [Name]: I am not using  
 it in any sense. I am trying to find out what you mean.  
 Dr. [Name]: I am not using  
 that term in any sense.



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COMMISSIONER McCUTCHEON: Surely what Dr. FitzGerald has been saying for some time is, if there is more money and you can buy the research and train a graduate and undergraduate students better, the public will benefit by having better trained people to serve them.

DR. FITZGERALD: I wish I could have said it as concisely.

COMMISSIONER BALTZAN: And if you can influence the department of your university to give you that money.

DR. FITZGERALD: No, I do not anticipate any difficulty along those lines.

DR. TOOGOOD: There is no difficulty there, there is just the difficulty of making it available.

COMMISSIONER FIRESTONE: May I now turn to paragraph 7, page 7, paragraph (c), in the third line where you say:

"At present only the Provinces of Manitoba and Quebec licence 'specialists' through their respective Colleges of Physicians and Surgeons."

I see the word specialists is put in quotation marks, why?

DR. FITZGERALD: I think this relates to the complete discussion of certification as presently laid down by the Royal College of Physicians and Surgeons of Canada and the specialists in the two provinces now do not necessarily, in fact they do not have to pass any standard examination of the Royal College in this province







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and perhaps, again, I am being parochial but only those specialists recognized by the Royal College are accepted for certification of fellowship standards and this, as I indicated further in the brief, has led to some hardships and difficulties even in this national group to try to resolve. At the moment we have not the answers but it has also been a problem in the past for men who have set themselves up as self-styled specialists without any licensing body governing them.

In these two provinces, the College of Physicians and Surgeons of Manitoba and Quebec do licence specialists in allergic disease.

COMMISSIONER FIRESTONE: Perhaps I might ask, are specialists in the field of allergy duly licensed in the Province of Quebec as specialists?

DR. LEGER: Yes, since 1956, the last five or six years.

COMMISSIONER FIRESTONE: And I suppose specialists operating in the Province of Quebec and the Province of Manitoba would not be self-styled specialists where you put them; in Quebec and Manitoba they are specialists as recognized by the province?

DR. LEGER: By the examination.

COMMISSIONER FIRESTONE: And the provincial College?

DR. LEGER: Yes.

COMMISSIONER FIRESTONE: This leads me to the next question; they would be specialists which are accepted as specialists in two provinces; why has the Royal College of Physicians and Surgeons so far not been



and perhaps, again, I am being over-cautious. I am not  
specialists recognized by the Royal College and the  
for certification of fellowship. I am not, and this, as  
I indicated further in the brief, has led to some prob-  
lems and difficulties even in this national group in  
try to resolve. At the moment we have not the answer  
and it has also been a problem in the past for men who  
have set themselves up as self-styled specialists without  
any licensing body governing them.

In these two provinces, the College  
of Physicians and Surgeons of Manitoba and Quebec  
license specialists in allergic diseases.

COMMISSIONER: I think I  
might ask, are specialists in the field of allergy duly  
licensed in the Province of Quebec as specialists?  
DR. LEBLANC: Yes, since 1961, the year

that or six years,  
COMMISSIONER: That's all. And I suppose

specialists operating in the Province of Quebec and  
the Province of Manitoba would not be self-styled  
specialists where you put them; in Quebec and Manitoba  
they are specialists as recognized by the province.  
DR. LEBLANC: In the examination.

COMMISSIONER: That's all. And the

COMMISSIONER: I think I should like to ask you  
to the next question; they would be specialists within the  
accepted as specialists in the provinces; was this  
level College of Physicians and Surgeons as far as



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prepared to accept and to certify specialists in this field? Are there any special reasons?

DR. FITZGERALD: No, sir, except in general, I speak as a Fellow in medicine and in general there has been no trend to licence the specialists in cardiology, endocardiology or any such specialties of medicine and it is not our province to pass judgment on the Royal College of Physicians.

I think it is interesting that in the last few years the College have felt it not in their interest to have a standard examination for career scientists, men who spend anywhere from five to seven years post-graduate to become clinical teachers and scientists of the kind to which Mr. McCutcheon referred at the most academic end of the scale as well as the most practical, which we think we belong at.

These hardships are with us and I cannot speak for the Royal College of Physicians, of course.

COMMISSIONER FIRESTONE: What is your case for such certification as specialists?

DR. FITZGERALD: I am not sure I have this specifically correct in the question you asked.

COMMISSIONER FIRESTONE: You have been pointing out, on page 8, that there are certain specialists, certified specialists, even though they deal with a minute fraction of the cases of illness in the population. Then you go on to say in your field, which is much more important numerically and in terms of problems, as important as other cases, you have not received that recognition.

Now, the question is why? Why would





preparation to answer and to possibly receive here in the

DR. FITZGERALD: No, sir, except in general, I speak as a Fellow in Medicine and in general there has been no threat to license the specialists in any field, anesthesiology or any such specialties of medicine and it is not our province to pass judgment on the Royal College of Physicians.

I think it is interesting that in the last few years the College have felt it not in their interest to have a standard examination for career scientists, men who spend anywhere from five to seven years post-graduate to become clinical teachers and scientists of the kind to which the Institution referred at the most academic end of the scale as well as the most practical, which we think we belong at.

These positions are with us and I cannot speak for the Royal College of Physicians, of course. COMMISSIONER: I am not sure I have case for such certification as specialists.

DR. FITZGERALD: I am not sure I have this specifically covered in the question you asked. COMMISSIONER: I am not sure. You have been pointing out, on page 8, that there are certain specialists, even though they deal with a minor fraction of the cases of illness in the population. They are on an as say in your field, and it is much more important and in terms of profit, as important as other cases, you have not received that recognition. Now, the question is why?



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your cases not be considered at least on an equal footing with cases that cover a much more minute fraction of the illness in the population?

DR. TOOGOOD: If I might speak to that point. Our desire to achieve recognition as a separate sub-specialty by the Royal College is just part of our desire to improve recruitment to this particular specialty. In this sense it is just a move which would have about the same importance as the move to try and channel more funds or make more funds available that would improve recruitment of top-flight personnel to this particular area of medical skill. The question as to why the Royal College decided that they would prefer not to do this is something that I do not think we are free to comment on. We are not in a position to decide the policy of the Royal College. We can say, as Dr. FitzGerald indicates, that we are not the only sub-specialty that is isolated in this way.

There are, in fact - most of the sub-specialties in medicine and surgery are not recognized as such by the Royal College but, de facto, they exist and large numbers of men spend their lives practising in these specialties.

COMMISSIONER FIRESTONE: Yes, and it has an important national implication because you are explaining to us that if such certification of a specialty would be worked out and would be accepted by the College it would encourage the flow of younger men into the profession and it is one of the methods of getting more trained people in the field. That is what you say you





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would like to encourage and that is what I understand is needed in Canada. Have you presented your case in these terms to the College?

DR. TOOGOOD: Many times.

COMMISSIONER FIRESTONE: Did you receive any answer?

DR. TOOGOOD: No.

COMMISSIONER BALTZAN: Is there an American Board of Allergy?

DR. TOOGOOD: Yes, sir, and an American Board of Obstetric Allergy.

COMMISSIONER BALTZAN: Is it true that a man who has a certification in internal medicine and has done special work in allergy is then recognized as an internist with a special interest in allergy or special interest in cardiology but in Canada we have not arrived yet at that point where we are classified, these minutes specialties, as entities?

DR. FITZGERALD: That is right.

COMMISSIONER BALTZAN: But it does not stop anybody there in practising or developing his career in allergies?

COMMISSIONER McCUTCHEON: It is a status symbol, is it?

DR. TOOGOOD: We look on it in a slightly less facetious way, that is all. We are not concerned with it as a status symbol, we are concerned with it as a method of improving recruitment of young, top-flight young people to this particular specialty. That, I think I can safely say, is the only reason that we have made







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application to the Royal College to be recognized as a separate specialty.

COMMISSIONER FIRESTONE: You are not doing it to have extra initials after your names?

DR. FITZGERALD: We both have our initials, our Fellowships.

COMMISSIONER FIRESTONE: You are talking about additional incentives to persuade young people to enter a profession which you feel is short of specialists and, therefore, it will help the cause of encouraging and increasing the supply. In this respect I think your comments have been very helpful and I would like to thank you, Dr. FitzGerald and your associates, for your helpful answers. Thank you very much.

COMMISSIONER McCUTCHEON: Just one question: surely all these specialties, you can fragment and fragment and fragment and you get to the point where it might initially be that your group, there would be so many sub-specialties that it leaves you right where you are now.





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4 DR. FITZGERALD: I don't think so.

5 I think the American Board of Examiners, to which another  
6 Commissioner referred, have sort of a purpose, a very  
7 real practical purpose as far as health services in that  
8 country are concerned. I think that, and if I may use  
9 again the career scientists, and a brief is coming from  
10 the Canadian Society of Clinical Investigation, they  
11 are in a more invidious position than we are as  
12 practitioners and teachers. A man may spend five to  
13 seven years in post-graduate training in really far from  
14 optimal conditions financially, and really not be  
15 recognized by the Royal College as equal to the man who  
16 has taken the examination after adequate training. This  
17 is another splinter group.

18 COMMISSIONER McCUTCHEON: You are  
19 Fellows of the Royal College?

20 DR. FITZGERALD: Yes.

21 COMMISSIONER McCUTCHEON: And what  
22 you are really talking about is fragmenting in accepting  
23 specialists?

24 DR. FITZGERALD: Now, with cardiology,  
25 haematology, dermatology, I have nothing against  
26 dermatologists, but they have been examined separately  
27 for certification. It is a splinter group. I think  
28 cardiology, endrology and haematology, considering the  
29 number of problems they have to deal with, apart from  
30 their clinical practice of medicine, are under the same  
problem that we are as far as characterising the struggle  
for these people, and if we do it province by province,  
I don't see how we can get any standard of practice. I







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4 think unless they indicate how these men are to be  
5 trained, it is going to be up to the individual  
6 universities to do as they wish.

7 DR. TOOGOOD: From a practical  
8 standpoint it has forced every member of this group to  
9 take two different sets of training. In other words,  
10 speaking from my own standpoint, it was necessary to  
11 take eight years' post-graduate training, of which five  
12 was in a specialty I was not going to use, and three  
13 was in a specialty that one was interested in. So this  
14 comes down to dollars and cents and availability of  
15 bodies to practise the specialty.

16 THE CHAIRMAN: Thank you very much  
17 gentlemen. As you know, we have a medical education  
18 project. It is under Dr. MacFarlane, as you know, with  
19 other personnel of the highest order. I take it that  
20 what we have been talking about for the last while  
21 properly falls within the sphere of that study, and it  
22 is to that study that what we have been talking about  
23 here for the last three-quarters of an hour will be  
24 directed, and they will get a copy of the record for  
25 that purpose.

26 DR. JOBIN: Mr. Chairman, the last  
27 submission this afternoon is the Canadian Council on  
28 Alcoholism. Their brief will be exhibit number 254.  
29 Mr. Stevens will lead the delegation.

30 ---EXHIBIT NO. 254: Submission of Canadian  
Council on Alcoholism.





SUBMISSION OF  
CANADIAN COUNCIL ON ALCOHOLISM

APPEARANCES: Mr. S.R. Stevens  
Dr. J.D. Armstrong  
Mr. H. David Archibald  
Mr. Robert Popham  
Dr. Wolfgang Schmidt

MR. STEVENS: Mr. Chairman and members of the Commission, to begin with I would like to introduce these gentlemen who are here with me. On my immediate left, Mr. Robert E. Popham, Assistant Research Director of the Alcoholism and Drug Addiction Research Foundation of Ontario. On the far left Dr. Wolfgang Schmidt, Supervisor of Social Work and Legal Studies for the Foundation. On my immediate right, Mr. H. David Archibald, Executive Director of the Foundation. On my far right, Dr. John D. Armstrong, Medical Director of the Foundation.

While all of us here work routinely for the Ontario Alcoholism and Drug Addiction Research Foundation, we are appearing today on behalf of the Canadian Council on Alcoholism. This Canadian Council consists of representatives of the provincially-supported research, treatment and educational organizations dealing with alcoholism in seven of Canada's 10 provinces.

The brief which you have received includes a 4-page summary at its beginning. In order to leave more time for questions and discussion, I propose at this time not to read that summary in full but to attempt, with your indulgence, to "summarize the







summary".

Alcoholism is a state of ill-health suffered by at least 200,000 Canadians. It is a complex condition, or series of conditions, partly physical, partly psychological and partly social. Its treatment and prevention therefore involves many different kinds of health facilities and personnel.

To professional health personnel in many fields - public health, occupational medicine, mental health, social casework, general medical practice, and many others - alcoholism appears as a peripheral problem. Yet when the work it creates for these people and the total number of sufferers are added up it becomes as a whole a very large problem to which there is no simple answer.

We have no panacea, no wonder drugs, in this field. Our belief however is that intensive research may so improve present methods of prevention, case-finding and treatment as to bring this health problem under at least as much control as other major public health problems like diabetes and tuberculosis.

To bring this about within a generation will require official encouragement, in terms of both finance and leadership. Consequently our brief describes what our experience leads us to believe are the most appropriate lines which such assistance should follow.

From the 16 recommendations listed as "A" to "P" on pages (ii) and (iii) of our opening summary, one might highlight at this stage the following:-





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4 Since specialized alcoholism clinics  
5 on the present scale have their greatest ultimate value  
6 as centres for research and for the training of community  
7 health personnel (rather than in terms of the small  
8 fraction of the alcoholic population that they are  
9 able to treat), they therefore present a particularly  
appropriate field for federal subsidization.

10 Since the most urgent problem is  
11 provision of more trained staff, a substantial amount of  
12 money should be made available for fellowships and  
13 internships to be used for those taking post-graduate  
14 training as physicians, psychiatrists, social workers,  
15 etc., within provincial or private alcoholism organiza-  
tions.

16 The establishment in larger metropolitan  
17 areas of special alcoholic receiving hospitals might:  
18 (a) actually reduce current pressure on the general  
19 hospital bed situation; and (b) provide an opportunity  
20 to staff the treatment of acute intoxication with  
21 personnel having the interest and competence to steer  
22 the maximum number of such patients into longer term  
treatment of the addiction itself.

23 An effort should be made to draw up  
24 standards that would be acceptable to professional  
25 authorities throughout Canada as to the type of treat-  
26 ment that would be considered insurable in this field,  
27 with a view to minimizing any avoidable repetition of  
purely palliative, short-term treatment.

28 Treatment of uninsured patients should  
29 be paid for out of public funds on the same basis of  
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4 acceptable standards, etc., as suggested above in  
5 relation to insurable treatment, whether this is done  
6 through an insurance mechanism or in some other way.

7 Prevention of alcoholism depends  
8 primarily on long-range educational endeavours calculated  
9 to improve: (i) the resistance of future generations  
10 to emotional stresses that underlie development of de-  
11 pendence on alcohol, and (ii) the mores within Canadian  
12 culture which give varying degrees of social sanction  
13 to the excessive intake of beverage alcohol by  
14 individuals.

15 Legal controls of an economic nature  
16 can also affect rates of prevalence of alcoholism  
17 appreciably.

18 The management, clinical or otherwise,  
19 of those already suffering from alcoholism can be  
20 improved mainly through:

- 21 (i) earlier recognition and diagnosis;  
22 (ii) acceleration of efforts to convey as much as  
23 possible of current knowledge and skills  
24 involved in treating alcoholism, to health  
25 and social counselling personnel of all types;  
26 (iii) intensification of scientific research in  
27 the field of alcoholism and other addictions.

28 Alcoholism is clearly a public health  
29 problem, whose solution can be hastened by appropriate  
30 federal assistance along the various lines suggested in  
this submission

THE CHAIRMAN: Thank you very much,  
Mr. Stevens. I would like to thank you for your courtesy





Stevens

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3  
4 in standing by so that we could proceed with the  
5 submission from the Academy of Allergy, because the  
6 two gentlemen were medical practitioners from Montreal,  
7 who had to return there this evening.

8 Your figure of 200,000 falling within  
9 the definition of alcoholism defined by the World Health  
10 Organization. That is accepted, is it, as a fairly  
11 solid figure in Canada?

12 MR. STEVENS: It is accepted as a  
13 solid figure in Canada, sir, and the Jellinek Formula  
14 from which it derived has been checked out by research  
15 done by the Ontario Foundation independently, which  
16 confirms the 200,000 figure as perhaps a minimum figure,  
17 rather than something which would be considered as  
18 being an overestimate.

19 THE CHAIRMAN: Then, when you come  
20 to the next statement: "It is known for example from  
21 sample studies that alcoholic employees in industry are  
22 about 6% of all industrial employees and have average  
23 annual absenteeism records that are from 10 to 20 days  
24 in excess of the normal". Does this follow from  
25 some specific study?

26 MR. ARCHIBALD: Yes, this follows from  
27 a specific study that the Foundation has conducted in  
28 a county in Ontario, in which there was a good representa-  
29 tion of the industrial population. It was conducted  
30 through Queen's University.

THE CHAIRMAN: Could it be made  
available to us, the results of this study?

MR. ARCHIBALD: Yes, Mr. Chairman.







Stevens

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THE CHAIRMAN: If you could forward it to us, or we could have our Secretary get in touch with you to obtain it. It would appear to be a document that we would have some value to us.

MR. ARCHIBALD: Yes sir. As a matter of fact, this study was conducted in a census year, 1951. We are now conducting a similar study in 1961 in the same county in order to compare the two.

THE CHAIRMAN: And I suppose it is yet in the process?

MR. ARCHIBALD: This is in process now.

THE CHAIRMAN: If it should be completed in the next few months, and it was available to us, we would be very happy to have it as well.

MR. ARCHIBALD: I think we should have at least some preliminary, but not a public, scientific document.

THE CHAIRMAN: Nor would we publish it, I mean make any public use of it in that sense, except with your co-operation and permission, but it would still be valuable information for our research staff, and for our own purposes.

MR. ARCHIBALD: Yes sir.

THE CHAIRMAN: From the law enforcement angle, you are coming forward with a proposition that should be accepted that .05 of alcohol in the blood be accepted as conclusive evidence of impairment. Apart from Saskatchewan, I take it there is no legislation with any real teeth in it to compel a person to submit to an



1961

1961

The first thing I noticed when I stepped out of the plane was the cold air.

It felt like I had been in a warm blanket for years and was suddenly thrown into a freezing bath.

I shivered as I walked down the stairs, my hands numb from the cold.

What we would have done if we had known the weather was so bad, I don't know.

But we went anyway, and we had a great time.

Of course, this story was told to me in a very casual way.

I don't know if it's true or not, but it sounds like a good story.

In the same way, I have heard many other stories about the weather.

They are all interesting, but I don't know if they are true.

Yet in the process of telling them, we learn a lot about ourselves.

And that is the point of the story. It is not just about the weather.

It is about the people who tell them and the people who hear them.

The story is a mirror, reflecting our own fears and hopes.

And that is why we tell them. We tell them to feel better about ourselves.

And that is why we listen to them. We listen to them to feel better about ourselves.

We tell them to feel better about ourselves, and we listen to them to feel better about ourselves.

And that is the point of the story. It is not just about the weather.

It is about the people who tell them and the people who hear them.

The story is a mirror, reflecting our own fears and hopes.

And that is why we tell them. We tell them to feel better about ourselves.

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And that is the point of the story. It is not just about the weather.

It is about the people who tell them and the people who hear them.

The story is a mirror, reflecting our own fears and hopes.

And that is why we tell them. We tell them to feel better about ourselves.



Stevens

9416

examination?

MR. STEVENS: This is the situation  
sir;

THE CHAIRMAN: But apart from fastening  
on some set figure, I suppose the first move would be  
to make it possible that any one who was involved in a  
motor accident where alcohol was suspected would have  
to submit to an examination?

MR. STEVENS: If it was legally felt  
to be desirable in connection with that particular  
accident, yes.





Examination

THE UNIVERSITY OF

1914

on the 1st day of June, 1914, the following persons were  
to take the examination in the subject of  
Latin, and the results were as follows:

to be admitted to the examination

At 10.15 a.m. the examination

to be held at the University of

Examination, 1914

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Stevens

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THE CHAIRMAN: This is achieved in Saskatchewan, as you know, by an indirect way of having you lose your licence if you refuse to submit to the examination. That has been upheld by the Supreme Court of Canada as being within the jurisdiction of the provinces. The figure of the alcoholic content has still been left open for judicial determination in each particular case.

MR. STEVENS: It is not .05 in Saskatchewan.

MR. ARCHIBALD: It is an open figure. The .05 is arrived at by a considerable body of research data, as perhaps you are aware, which relates the accident or responsibility of the accident in relation to blood alcohol levels.

In the studies, and perhaps Mr. Popham would like to comment on this; in the studies that have emerged so far, the responsibility factor for accidents doesn't seem to have increased significantly below .05, but the factor does increase quite considerably between .05 and .10, and this rises very markedly about 1.0, so there are rather good data in the background.

Again, with this data, we would be very pleased to make this available to you.

THE CHAIRMAN: There is, as you will appreciate, a divergence of opinion on just what the figure might be.

MR. ARCHIBALD: Quite.

THE CHAIRMAN: Such as the opinions from Dr. Smith and Dr. Vavonich diverge.





Archibald

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MR. ARCHIBALD: As you could probably guess I am quoting from Dr. Smith.

COMMISSIONER STRACHAN: To be reliable, how soon must these tests be made after the accident?

MR. ARCHIBALD: Generally alcohol is oxidized on the average of about one ounce an hour so the sooner following the accident the test can be taken, the better.

THE CHAIRMAN: It could be worked out if there had been no change in the circumstances, the man has not had the opportunity to take three or four slugs after the accident or that kind of thing?

MR. ARCHIBALD: Yes.

THE CHAIRMAN: As one fellow said, he took one to sober up.

MR. ARCHIBALD: Yes.

THE CHAIRMAN: This may not be the place for this remark, but a lawyer friend of mine told me he was called to the police station to look after the interests of a rather well-known businessman who found himself in difficulties, having had too much. So, he said, "What did you do since the accident?" He said, "I went home and had one to sober up."

MR. STEVENS: Was it effective?

THE CHAIRMAN: It was effective. He told him to plead guilty. Professor Firestone?

COMMISSIONER FIRESTONE: Mr. Stevens, you spoke about 200,000 Canadians, more than 200,000 Canadians, being afflicted by excessive use of alcohol, and you also say on page 1 that about 6% of all industrial







Stevens

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employees have an average annual absenteeism record from 10 to 20 days in excess of normal. I presume this is for the year?

MR. STEVENS: That is correct, yes.

COMMISSIONER FIRESTONE: Has your Association made any estimate of the economic losses to the nation due to excessive alcoholism?

MR. STEVENS: Did that come out in the study, do you recall?

MR. ARCHIBALD: Not in those terms. We estimated solely on the basis of the average absenteeism rate related to the average income. Beyond this, we haven't gone. As you know, there are so many statements in this field as to the loss, economic loss. There is no question it is very high and, sir, to be definitive on this at this point and at this time, is enormously difficult.

COMMISSIONER FIRESTONE: Do I understand you correctly, sir, in saying that you have made some estimates of the income losses due to absenteeism?

MR. ARCHIBALD: Some estimates, yes.

COMMISSIONER FIRESTONE: Because, if such estimates were available, this would be a reflection of some of the economic losses incurred by society due to excessive use of alcohol.

MR. ARCHIBALD: Yes.

COMMISSIONER FIRESTONE: Could that information be made available?

MR. ARCHIBALD: Yes, this could be estimated.





Archibald

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COMMISSIONER FIRESTONE: And made available.

MR. ARCHIBALD: And made available to you.

COMMISSIONER FIRESTONE: In the form of a written communication to our Secretary.

THE CHAIRMAN: You would be doing that from the basic information of the surveys of 1951 and the repeat of 1961. We could do that ourselves from the same basis.

COMMISSIONER FIRESTONE: I understood you had already done it.

MR. ARCHIBALD: On the basis of our original studies.

COMMISSIONER FIRESTONE: You prepared such estimates?

MR. ARCHIBALD: Yes, these will be again prepared on the basis of our current study.

COMMISSIONER FIRESTONE: If we get your studies can we also have the additional estimates which were prepared based on these studies?

MR. STEVENS: Yes.

MR. ARCHIBALD: These will be, of course, minimal estimates based on the work loss ratio.

THE CHAIRMAN: We have the work loss estimate. Our own research people can make an independent estimate.

COMMISSIONER FIRESTONE: Exactly. That is exactly the objective. You will have some estimates and our own research people will have some estimates and





THE UNITED STATES OF AMERICA

Washington, D.C.

OFFICE OF THE ATTORNEY GENERAL

DEPARTMENT OF JUSTICE

IN RE: [Illegible Name]

Case No. [Illegible]

From the [Illegible] of the [Illegible]

The report of [Illegible] dated [Illegible]

is hereby [Illegible]

you are [Illegible]

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Stevens . 9421

we of the Commission will want to look at both and if they are different we will want to know why. This gives us of the Commission an opportunity to see the problem in perspective.

Now, do you have any estimates of what would be required in financial terms or in terms of cost, to implement some of the recommendations which you have submitted in this brief?

MR. STEVENS: At this time I would think that would be rather difficult to do. From the Federal Government at this time there has been very little in the way of support given to the alcoholism problems. The whole question of the development of services for combating the alcohol problem is still in an expansion and we, in the Province of Ontario, for example, have just developed a blueprint, what we call a blueprint, for our guidance in the combating of the alcohol problem over the years to come, the next 10 years.

This shows very substantial funds are required in the field of education, in the field of research and certainly in the field of treatment. Whether it is possible at this time to put this down in dollars and cents - have you got any specific figure?

MR. ARCHIBALD: I haven't come to a specific figure.

COMMISSIONER FIRESTONE: You may not have come at this stage to a figure, but it would help us as Commissioners in trying to make recommendations, if any are indicated, to be able to say we are doing this in part on the recommendation of your Association and in





Archibald

9422

your considered opinion grants - where coverage or payments of this order would be proper and would be helpful to achieve an objective, which you have stated in here. I appreciate you may not have had the opportunity to do this type of work. Would it be possible to give some further thought on what are the financial implications of your recommendations, or some of your recommendations?

MR. ARCHIBALD: Yes, as a matter of fact, given a little time and opportunity to work on this, we could come up with some reasonable estimates on the cost factor, particularly in Ontario. We will try, of course, to look at the whole of Canada.

THE CHAIRMAN: If you have some reasonably reliable figures for Ontario the rest of the country will pretty well fall into the same category.

MR. ARCHIBALD: We are actually, as Mr. Stevens pointed out, working at this present time on costing or pricing out the average blueprint for the formula we have developed for this province over the next 10 years. This data will certainly be made available to you.

COMMISSIONER FIRESTONE: It would be very helpful, sir, to have this information for Ontario or anything additional for the rest of the country made available to us. If you could then add, perhaps, some of the economic advantages you would expect to get from the implementation of this program: let us say you come forward with a proposal that Canada, as a whole, should spend \$10,000,000 and you could see our economic losses







Stevens 9423

at the moment were 40 to 50 million and we might use that \$10,000,000 as it would improve the health of the nation and it would be an economic saving to the nation. Thank you very much.

MR. STEVENS: We would be glad to do that, sir.

COMMISSIONER FIRESTONE: One other question, if I may, sir: if there were developed in Canada a plan for comprehensive medical care services, or plans, would you feel that medical services could treat alcoholism covering 1, short-term treatment and 2, long-term treatment as defined in paragraph 59 of your submission?

MR. ARCHIBALD: Shall I speak to this?

MR. STEVENS: If you would.

MR. ARCHIBALD: I think the answer to both of your factors would be yes. We would encourage and hope very much that this disorder would be considered as an insurable illness. The question of short-term versus long-term is an interesting one. Some plans do provide for what is called short-term treatment at the moment, which is a matter of a few days in the detoxication stage, which is the treatment of intoxication, but not the treatment of the basic condition of alcoholism.

We rather feel from the straight economic point of view it would be better to subsidize treatment of alcoholism itself if one had to choose between the two. Dr. Armstrong?

DR. ARMSTRONG: I wanted to add one sort of warning there. I think what has happened is that





Armstrong

9424

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2  
3 under some schemes treatment has been insurable for what  
4 one might call the treatment of the traditional sickness,  
5 the acutely alcoholic patient with not too clear recogni-  
6 tion of the serious ongoing problem which is as indicated  
7 in the brief, may be a mixture of psychological and  
8 physical factors. That means then that the coverage for  
9 the long-term aspect of treatment is often neglected.  
10 One thing that has given us a bit of concern is that  
11 in recognizing this problem there has possibly been a  
12 trend for some insuring groups to swing the other way  
13 and take the view that this one should only be treated,  
14 those cases which stay in treatment for a long time.

15 This, of course, would be possibly  
16 missing the point, because there are many occasions  
17 where hospitalization need only be for a short time.  
18 If we are to eliminate that aspect we might fail to  
19 insure some patients who could benefit by brief and  
20 relatively economical treatment.

21 COMMISSIONER FIRESTONE: I therefore  
22 understand that you are recommending to include both  
23 short-term and long-term treatment. Thank you very much.

24 THE CHAIRMAN: Is there a liaison  
25 between the various provincial foundations and Alcoholics  
26 Anonymous?

27 MR. ARCHIBALD: Yes, Mr. Chairman, I  
28 think by and large all the provincial organizations in  
29 this field work rather closely, particularly at the  
30 treatment level, work rather closely with Alcoholics  
Anonymous. Certainly we do in Ontario, and certainly  
the other provinces, particularly where Alcoholics







Archibald . . . . 9425

Anonymous are effective and strong in terms of size and organization. We traditionally feel Alcoholics Anonymous represent one of the rather good resources that is available to help people particularly in smaller communities.

THE CHAIRMAN: We all know of rather pronounced cures.

MR. ARCHIBALD: That is traditionally the first resource. The situation is a little different in Quebec.

THE CHAIRMAN: Citizens that have been saved and gone on to very fruitful lives. Dr. Strachan?

COMMISSIONER STRACHAN: In the field of prevention, do your organization or the provincial bodies do anything in respect to education of the teenager, any efforts along that line at all?





N/ss

Archibald 9426

MR. ARCHIBALD: Well, all of the Provincial organizations are particularly and specifically interested in this phase and various programs have been developed across the country. In Ontario, which we can speak here most comfortably about, we have worked with our Department of Education of the Province.

We have developed materials in cooperation with the Department of Education. Two main instruments at the moment, one: Teachers' manual. This is provided for all of the physical health education teachers of the Province by the Department of Education. We prepared it in our Foundation.

Secondly, --- oh, yes, a sample of that, by the way, is included in the brief. Secondly, and another document which is a --- dare I say comic book? It's a pictorial presentation of significant research findings in this field and this document has been made available to all of the high school students in the Province of Ontario again through the Department of Education.

Now, these two instruments, as a matter of fact, are being used also in quite a number of other Provinces. For example, I learned this morning that Prince Edward Island will be using our data, our document for presentation to the school children in that Province. Similarly, this is developing across the country.

COMMISSIONER STRACHAN: Have you any reason to believe that it is a fruitful effort, or has it been in operation long enough to draw any conclusions?

MR. ARCHIBALD: It has not been really





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TORONTO, ONTARIO

Archibald 9427

in operation. I suppose, to some extent, it's an act of faith that the acquisition of knowledge, specific knowledge on the part of younger people will in some way tend to offset a tendency to become involved in an alcoholic disorder later on.

Whether or not this would be the result, we don't know.

THE CHAIRMAN: Thank you very much, Mr. Stevens, Mr. Archibald, and your associate. We appreciate the intensity of your interest in this, you might call very elusive and difficult field of illness that is all too prevalent in the country as a whole, but we appreciate too, that these foundations and organizations have come only recently in the field and the whole subject is really one for study, perhaps, than being able to suggest any specific remedies or cures. For the moment, we are just experimenting. Thank you very much.

MR. ARCHIBALD: Thank you, sir.

THE CHAIRMAN: We will adjourn now until tomorrow morning at nine-thirty.

---Whereupon the hearing was adjourned.



# ROYAL COMMISSION ON HEALTH SERVICES

HEARINGS

HELD AT

TORONTO

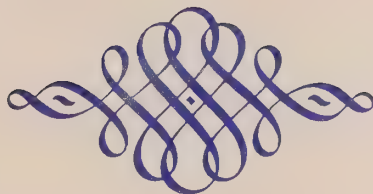
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VOLUME  
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THE CANADIAN HOSPITAL ASSOCIATION

THE ONTARIO HOSPITAL PHARMACEUTISTS' ASSOCIATION

and

THE CANADIAN HOSPITAL ASSOCIATION  
PHARMACEUTISTS' ASSOCIATION



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VOLUME 50

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ROYAL COMMISSION ON HEALTH SERVICES

Proceedings of the hearings  
held in Toronto, Ontario,  
on the 10th day of May, 1962.

COMMISSION MEMBERS:

Chief Justice EMMETT M. HALL -- Chairman

Miss ALICE GIRARD, R.N.

Dr. C.L. STRACHAN

Dr. ARTHUR F. VAN WART

Mr. M. WALLACE McCUTCHEON, Q.C.

Prof. O.J. FIRESTONE

Dr. DAVID M. BALTZAN

COMMISSION COUNSEL:

Mr. R.N. HALL, Q.C.

MEDICAL CONSULTANT:

Dr. PIERRE JOBIN

DIRECTOR OF RESEARCH:

Prof. BERNARD BLISHEN

COMMISSION SECRETARY:

Mr. N. LAFRANCE







9428

Toronto, Ontario,  
Thursday, 10th May, 1962.

--- On commencing at 9.30 a.m.

THE CHAIRMAN: Yes, Dr. Jobin?

DR. JOBIN: Mr. Chairman, the first presentation this morning will be made by the Canadian Hospital Association and this brief will be known as Exhibit 255. Mr. Martin will lead the delegation.

--- EXHIBIT NO. 255: Submission of the Canadian Hospital Association.

SUBMISSION OF THE CANADIAN HOSPITAL ASSOCIATION

Appearances: A.H. Westbury, 1st Vice-President, C.H.A.  
Executive Director, Montreal General Hospital  
W. Douglas Piercey, M.D., Executive Director, C.H.A.  
S.W. Martin, Immediate past-president, C.H.A.  
Executive Secretary-Treasurer, Ontario Hospital Association, Toronto.  
Mother Maille, Director, C.H.A. Provincial Superior, Montreal, Quebec.  
C.N. Weber, Director, C.H.A., Kitchener, Ont.  
George McCracken, Assistant Director, C.H.A.

MR. MARTIN: Mr. Chairman and members of the Commission, I first of all would like to express on behalf of our President, Chief Judge Nelles Buchanan, his sincere regret that he is unable to be here this morning. As I have already reported to you, he had a problem that arose in connection with one of the judges who had to be hospitalized, which seems rather coincidental, and he had to take his place. However, he sends his sincere regrets and we pass them along to you.





Martin

9429

This group has been assembled, Mr. Chairman, in support of the brief which we have already submitted to you and also to answer any questions which any member of the Commission may have after we have had a chance to submit our summary and recommendations.

The Canadian Hospital Association, incorporated under the Dominion Companies Act as a non-profit organization (Appendix I), welcomes this opportunity of expressing the views of the Association on matters relating to the provision of health services for the people of Canada. Since hospitals play an essential role in the provision of health services, they are vitally concerned in any program for making these services more readily available.

The Canadian Hospital Association is a federation of provincial hospital associations, Catholic hospital conferences and the Canadian Medical Association - seventeen active members in all (Appendix II). It maintains liaison and seeks close co-operation with the federal and provincial governments and voluntary organizations in the health field (Appendix III).

Our submission has been prepared in our national office at 25 Imperial Street, Toronto, Ontario and approved by the Board of Directors (Appendix IV) of the Canadian Hospital Association. It was circulated in draft form to all the member associations and conferences. The Association has also received valuable assistance and advice from the Boards of Directors of our member associations and Catholic hospital conferences which we gratefully acknowledge. Although the Canadian Medical Association







Martin

9430

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2  
3 is an active member of the Canadian Hospital Association,  
4 it took no part in the formation of this brief. The  
5 views expressed and the recommendations made are solely  
6 those of the Canadian Hospital Association representing  
7 the hospitals of Canada.

8 The summary of our recommendations is  
9 as follows:

10 1. That local ownership, management  
11 and control of hospitals should continue to be the  
12 responsibility of local communities and non-profit  
13 organizations.

14 2. That the Hospital Insurance and  
15 Diagnostic Services Act be amended to include the care  
16 of the mentally ill with special emphasis on adequate  
17 emergency services at point of need.

18 3. That the Hospital Insurance and  
19 Diagnostic Services Act be amended to include the provi-  
20 sion of out-patient services, as defined in the Act, as  
21 a required condition in every Dominion-Provincial  
22 agreement.

23 4. That in order to make the most effi-  
24 cient use of all types of hospital facilities, the present  
25 hospital construction grant program be amended to provide  
26 more generous grant assistance for the construction of  
27 facilities, alternative to the acute general hospital,  
28 suitable for convalescent, rehabilitative and domiciliary  
29 care.

30 5. That there be established, at the  
local and regional level, hospital planning councils to  
plan for facilities and services at these levels. These





Martin

9431

councils should be comprised of individuals, agencies and parties concerned with the provision, maintenance and operation of hospital services.

6. That the Hospital Insurance and Diagnostic Services Act be amended to include depreciation on buildings and the payment of interest on capital debt in the reimbursable cost.

7. That medical and hospital representatives be afforded the opportunity to participate with government hospital plan officials in developing standards on which the reimbursable cost formulas are based.

8. That the exercise of the hospitals' function in the maintenance and control of the quality of patient care be recognized by both the Dominion and Provincial Governments as an element of cost in establishing the reimbursable cost.

9. That the function of hospitals in preventing disease and illness be recognized by both the Dominion and Provincial Governments as an element of cost in establishing reimbursable cost.

10. That the present method of financing medical research in hospitals by means of grants be continued and that such funds be substantially increased.

11. That the Hospital Insurance and Diagnostic Services Act be amended to include the cost of transportation of patients, particularly in those hospitals serving a rural community, in the reimbursable cost.

12. That grants be made available to facilitate studies of the need for and utilization of







Martin

9432

medical, para-medical and nursing personnel in hospitals.

13. That in order to provide personnel in the quantity and quality required to take care of the sick, hospital insurance plans must finance hospitals in their endeavour to:

(a) Improve public opinion of hospital employment.

(b) Organize recruitment campaigns.

(c) Improve hospital salaries and working conditions.

14. That hospitals continue to operate Schools of Nursing.

15. That the training of medical and health personnel by hospitals should continue to be recognized as an element of cost and funds for this purpose should be provided in establishing the reimbursable cost. Further, it should be recognized that the various hospital and professional associations are properly in the educational field and to the extent that they do engage in this field, the expenditures by hospitals for participation in these programs should be recognized as part of the reimbursable cost.

16. That the following order of priority be followed in the provision of health services:

(a) No health care plan more comprehensive than that which now exists should be introduced until it can be adequately financed without detracting from present health services.

(b) Studies should be conducted to





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determine the need for additional  
hospital facilities.

(c) Adequate hospital facilities should  
be provided, particularly lower-cost  
alternative facilities to acute hospital  
care.

(d) More adequate facilities for the  
mentally ill should be provided.

(e) Increased education and training  
of health workers should be undertaken.

(f) Increased activity in the field  
of preventive medicine should be under-  
taken.

This is the summary of our recommendations,  
Mr. Chairman, and I believe that we have attempted in  
preparation of the brief to follow through fairly well  
on the suggested direction that came from the office of  
your Secretary. We submit this for your consideration  
and we are prepared to answer any questions that you  
have found within the context of the brief.

THE CHAIRMAN: Thank you, Mr. Martin.  
We have found your submission of the Canadian Hospital  
Association to be a very valuable document and it contains  
information that we require and suggestions that will be  
of value to us. As you have indicated, there are some  
areas in which we may want some further enlightenment  
this morning and there will be questions from some or all  
of the members of the Commission.

The fact that there is in existence in  
Canada the hospitalization program, a program under the







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4 authorization of the provinces but jointly financed by  
5 the Federal and Provincial Governments, makes the opera-  
6 tion of the hospitalization plan a subject of considerable  
7 importance because it is a plan in operation and could  
8 be the prototype or, in some way, some indication of how  
9 some other health services plan or plans might function.

10 I suppose in a general way one may ask  
11 a very short question that may take a long time to answer  
12 and the answer would have to be fragmented and that is:  
13 is the Canadian Hospital Association satisfied with the  
14 work of the Hospital Insurance and Diagnostic Services  
15 Act in a general way? I know you have a number of  
16 recommendations here in which you ask for changes and  
17 so forth but, by and large, is the thing working out  
18 reasonably well?  
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4 MR. MARTIN: As you are so well aware,  
5 there actually being no national hospital insurance plan  
6 but actually ten provincial plans operating under this  
7 heading. I would say it is rather difficult to give an  
8 all-embracing answer to your question. But I would  
9 think -- and I would hope that some of the other members  
10 of the delegation would pick this one up, because I am  
11 sure it is very important from your standpoint -- speaking  
12 as an individual it would seem to me that basically on  
13 the whole not many of the hospitals or their associations  
14 would say that the plans that have been in operation  
15 haven't had many good features about them, and their  
16 operation has cleared a number of problems that did  
17 exist before the introduction of the plan. But like all  
18 pieces of perhaps progress, you clear up some and you  
19 create others. Basically I think that would be my  
20 statement.

21 I know that speaking from my own  
22 knowledge, perhaps from the province I am in, that none  
23 of the provinces would wish to return to the situation  
24 which we had before the inception of the plan.

25 I think perhaps some of the other  
26 delegates would like to speak on it.

27 MR. WEBER: Mr. Chairman, on page 6  
28 I think it sets out the answer just as fully as we can  
29 make it. "The Association believes that national  
30 hospital insurance, as now operating in Canada, is of  
great benefit to Canadians and in general for Canadian  
hospitals which provide patient care. It is our opinion,  
however, that certain sections of the Act and its







Martin

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1 regulations, should be amended."

2 I think that in a general way answers  
3 the problem more than we can in a brief statement.

4 THE CHAIRMAN: When you come to these  
5 matters in which you say there should be some change,  
6 dealing not in the order in which they are suggested,  
7 out-patient services, you recommend that the out-patient  
8 service be extended, as I understand it, and that, of  
9 course, does not require an amendment to the Act and is  
10 a matter which is solely up to each individual province.  
11 The facilities now exist whereby a province can take  
12 advantage of the provisions of the Act to inaugurate  
13 out-patient service. But having said that that should  
14 be done, are you in a position to say that the hospitals  
15 throughout Canada are in a position to put out-patient  
16 services into operation if any one or more provinces  
17 says: "Well, we should say we are prepared to start  
18 this on such and such a date."?

19 MR. MARTIN: Mr. Chairman, I think  
20 the context of our recommendation is the fact that many,  
21 many hospitals are providing a degree of out-patient  
22 service now to a varying degree. The problem that is  
23 inherent in this is that with the inception of a hospital  
24 insurance plan and without the coverage of so-called  
25 out-patient services you have a peculiar situation  
26 which is very hard to understand on the part of the  
27 public which suggests that hospital services are avail-  
28 able under a plan but that then for certain reasons  
29 out-patient services are not available to them on a  
30 pre-paid basis under the hospital insurance plan. We





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4 submit that this causes complications no end as far as  
5 the hospitals are concerned, because the public has  
6 great difficulty to understand if they get into a bed  
7 they get certain things where they can't if they are  
8 able to walk in and out again. The degree to which  
9 they can or cannot be supplied can to a large measure  
10 be measured by the fact that they are being given at  
11 the present time. But it is a question of how they  
12 are being paid for.

13 THE CHAIRMAN: As you will see, this  
14 matter of out-patient service is, in the judgment of  
15 many, tied to utilization in hospitals. What do you  
16 say regarding the bringing into operation of out-patient  
17 service on a pre-paid basis on terms of bed utilization?  
18 Would it ease the situation or make it worse?

19 MR. WESTBURY: If I might add to what  
20 Mr. Martin has said, I feel it is probably a question of  
21 whether we have to build additional beds or provide  
22 additional out-patient facilities. As Mr. Martin has  
23 said, we find the cases where people could be dealt with  
24 on an out-patient basis but are being hospitalized,  
25 and that is creating a very great problem in the matter  
26 of waiting lists and finding accommodation for acute  
27 and emergency cases. If it is a question we have to  
28 provide beds to catch up on the waiting lists to create  
29 a demand for internal care, would it not be cheaper  
30 to provide facilities on an out-patient basis?

31 COMMISSIONER McCUTCHEON: Having done  
32 that, at what stage would you extend the plan to render  
33 service provided at the doctor's office?







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4 MR. WESTBURY: Well, I think that is  
5 quite a factor which will come into it. There are quite  
6 a number of out-patients who would go into a doctor's  
7 office, but we are dealing with medical tests, not the  
8 hospital part. The hospitals are able to give the  
9 tests for the benefit of doctors in making their  
10 diagnosis. It is true that some doctors do have portable  
11 x-ray machines or cardiograph machines in their office.  
12 But if these facilities were extended to patients on an  
13 out-patient basis, that would also have to be extended  
14 to tests in the doctor's office.

15 COMMISSIONER McCUTCHEON: I understand  
16 your point, but I don't know where you extend it after  
17 that.

18 MR. WESTBURY: Yes. You take, for  
19 example, a patient in an outlying district perhaps  
20 40 or 50 miles from a hospital. It would be rather  
21 foolish to send that patient 40 or 50 miles for an x-ray  
22 when it could be done in the doctor's office. That is  
23 one of the mechanics that would have to be worked out.

24 COMMISSIONER VAN WART: You spoke of  
25 the problem of beds. Do you mean acute beds or beds of  
26 another type?

27 MR. WESTBURY: No. One of our efforts  
28 in bed capacity could be on the rehabilitation side.  
29 That, of course, would release beds in the acute general  
30 hospital. It may in time catch up with the backlog of  
patients requiring acute care.

COMMISSIONER VAN WART: Many of these  
patients would not require acute beds.





Westbury

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MR. WESTBURY: Could be treated on an out-patient basis.

COMMISSIONER VAN WART: Or beds connected with a situation where it was a cheaper bed?

MR. WESTBURY: Yes, they could be treated by beds of a cheaper nature. I think we all know of cases where patients have been put in an acute bed merely for diagnostic purposes. If it is an investigative case then it is being withheld from an acute or emergency case.

DR. PIERCEY: I think in trying to answer your direct question, Mr. Chairman, was the hope that this be part of all provincial plans. It was our hope that this would ease the situation of the acute general hospital.

THE CHAIRMAN: Going to the wording of your recommendation number 3, "That the hospital insurance and diagnostic services be amended to include the provision of out-patient services, as defined in the Act, as a required condition in every Dominion-Provincial agreement," every province must comply with that in order to participate in the grant?

MR. MARTIN: That is right, Mr. Chairman.

THE CHAIRMAN: Thank you.

MR. WEBER: So long as you don't have that uniformity throughout the provinces there will be a great deal of confusion and a great deal of dissatisfaction.

COMMISSIONER McCUTCHEON: There are







Weber

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3 provinces who don't like uniformity.

4 COMMISSIONER FIRESTONE: But you are  
5 in favour of minimum standards throughout Canada?

6 MR. WEBER: It is not so much the  
7 fact of uniformity, but I think all the people in other  
8 provinces feel the same.

9 MR. MARTIN: I think in relation to  
10 your question, Mr. Chairman, I don't think we are suggesting  
11 that the extension to out-patient services would  
12 necessarily reduce to a marked degree the amount of  
13 people that are in beds, but we do think it would put  
14 the whole situation to better use, that is the facilities  
15 that had been created would be used better. So we  
16 don't think we would be naive to suggest that this would  
17 be a saving, that there would be a reduction in dollars.  
18 I think it would take more dollars but I think would  
19 provide a better level of care through the piece.

20 COMMISSIONER McCUTCHEON: Why a better  
21 level of care? You are providing the care in your  
22 out-patient departments.

23 MR. MARTIN: Because of the question  
24 of prepayment in some form or another in the hospital  
25 plan makes the services available to them on a prepaid  
26 basis so they don't have to ---

27 COMMISSIONER McCUTCHEON: Are there  
28 any services providing an out-patient clinic which  
29 refuse people because people can't pay, say, in the  
30 Province of Ontario?

MR. WEBER: I would say that there  
are hospitals today in the city that are not providing it





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Weber

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4 I am not from the city, I am from outside, but I think that  
5 there are communities of substantial population who  
6 don't provide them now.

7 COMMISSIONER McCUTCHEON: I am asking  
8 about the hospitals who provide them now.

9 MR. MARTIN: I think we are not just  
10 referring to hospitals which provide them through the  
11 clinics but also the diagnostic service, and so on.

12 COMMISSIONER BALTZAN: I assume you  
13 don't deny or refuse anybody who requires such things  
14 that are required in the out-patient service departments,  
15 but your problem is when you do provide it you do not  
16 get compensation for it, or do you?  
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Martin 9442

MR. MARTIN: This is difficult to answer on a comprehensive basis right across the country. It is difficult to answer your question specifically as far as the country as a whole is concerned.

COMMISSIONER BALTZAN: How is it in this Province?

MR. MARTIN: In Ontario if you are talking about organized public out-patient clinics ...

THE CHAIRMAN: We will be dealing with the Ontario Hospital Association next.

COMMISSIONER BALTZAN: I want to know, because we have learned in certain provinces only emergency out-patient services are being paid for under the Act. In some provinces even that isn't included under the Hospital Diagnostic Act. We will learn a little bit later what the category here is. The Ontario people are coming in later. I will hold up my questions.

THE CHAIRMAN: If this recommendation should be accepted by the Federal Government or the Provincial hospital associations, are the hospitals of Canada in a position to provide this service, or how long would it take before this service could be expected to be put into operation? You are no doubt familiar, some sixty days ago or so in Saskatchewan the Government indicated that they were going to follow what you are recommending, going to adopt what you are now recommending, and the Hospital Association came and said they couldn't do it, they weren't in a position to accept the responsibility within the period the Government wanted to put it into operation.





Martin 9443

MR. MARTIN: I could say they could accept the responsibility to the degree they are doing it now which is fairly extensive.

THE CHAIRMAN: That is in those areas where it has been developed. Would you expect that every hospital would provide an out-patient department?

MR. MARTIN: Not an organized out-patient clinic setup, but there would be varying degrees of services available on an out-patient basis.

COMMISSIONER BALTZAN: Are these services X-ray services, laboratory services, physiotherapy?

MR. MARTIN: Yes.

MOTHER MAILLE: Mr. Chairman, I think we are speaking of planning for the future because, really at the present time it is sure that this would bring some problems, but if this point is not accepted by your Commission there is some problem just the same. If you are planning for the future, what can answer for the need and give what the patients are asking for, then, sure all of the provinces would have to work toward this to answer the best possible way.

THE CHAIRMAN: What you are saying is that with sufficient time the hospitals could provide the services you are asking they should give.

MR. WESTBURY: That is right.

THE CHAIRMAN: Now, in connection with the construction of hospitals, and this matter of how many hospital beds are given in any community, what does the future show of what is probably the ratio of beds to population, that is acute beds? Have you made any study of that?







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4 MR. WEBER: The answer is we haven't,  
5 Mr. Chairman, and I think in this relation one would have  
6 to take with this the suggestion of our planning recommen-  
7 dation, because I think it is recognized that overall  
8 ratios or averages are difficult to come up with. You  
9 can talk about them, but they are difficult to apply  
10 because so much depends on local situations in certain  
11 areas, and therefore there are certain standards, as you  
12 know, that are talked about in the trade fairly freely,  
13 but even then therefore it is difficult to apply in any  
14 given situation, so that we emphasize more the need for  
15 intensive planning participated in by the hospital  
16 medical nursing people with the assistance, probably, of  
17 Government, so that the needs could be determined in  
18 that particular society.

19  
20 THE CHAIRMAN: What is the Canadian  
21 Hospital Association's view as to whether the beds for  
22 treatment of the mentally ill, where those beds should be  
23 located?

24 MR. MARTIN: I don't think, Mr.  
25 Chairman, we specifically mentioned that point in our  
26 brief. We, of course, are in favour of the psychiatric  
27 beds in acute general hospitals for short treatment. I  
28 think the feeling of our Association would be that we  
29 would like the mental beds to be more readily available to  
30 consulting medical services. The pattern today is very  
often that the mental hospital is well away from the  
centre of medical practice and it is not always for the  
easy benefit of the consulting staff such as the acute  
general hospital has, your staff being there. I think we





Martin 9445

could go that far. We would favour, I think, in general small units rather than large units we see today, and perhaps they shouldn't be quite so far out in the country.

THE CHAIRMAN: We were told by those competent in the field that the day of these outside hospitals is now in the past, and that the treatment of the mentally ill should be in exactly the same milieu as the physical. Do the Canadian Hospitals favour either establishment of wards within the hospitals or of wings adjacent or connected to the hospital as a solution for the provision of beds for the mentally ill?

DR. PIERCEY: I think we would want to divide that probably into two divisions, Mr. Chairman. Certainly we favour a psychiatric ward in the general hospital for the short-term treatment of the mentally ill. We recognize, of course, there is such a thing as chronic mental illness and I think this requires a specialized type of hospital or wing to look after this.

THE CHAIRMAN: But close to the medical service.

DR. PIERCEY: That is what our opinion would be, I think.

THE CHAIRMAN: Would you see the hospital operating both sections, or would you have a separate administration for the hospital of the physically ill as distinct from the wing or section for the mentally ill?

DR. PIERCEY: As an Association, Mr. Chairman, I don't think we have considered that point.







Piercey 9446

As the Commission knows, the majority of mentally ill in this country have a different type of administration today than the acute general hospitals.

THE CHAIRMAN: They are practically all operated by Provincial Governments and fully supported by Provincial Governments.

DR. PIERCEY: Yes. We couldn't speak on that particular point, because it hasn't been explored by us.

THE CHAIRMAN: The integration of the beds for the mentally ill either in the hospital or in the wing would meet one of your recommendations of having the care of the mentally ill brought under the supervision of the Hospitals and Diagnostic Services Act from which they are now excluded.

MR. MARTIN: They are excluded.

THE CHAIRMAN: Still in the hospitals.

MR. MARTIN: For the acute phase in a general hospital.

THE CHAIRMAN: Your recommendation is that they should not have been A, excluded at all and having been excluded they should now be included.

DR. PIERCEY: That is the recommendation.

COMMISSIONER VAN WART: Mr. Chairman, in speaking about administration, your number one recommendation is that local ownership, management and control of hospitals should continue to be the responsibility of local communities and non-profit organizations. You wouldn't, then, according to your resolution No. 1 have Government-operated wings attached to your acute hospitals for mental cases.





Piercey 9447

DR. PIERCEY: I think you could read that into it. It actually isn't a matter as yet of discussion between the Hospital Association and the Departments of Health of Governments. We would certainly think our Provincial Associations would be quite willing to sit down and look into this, but we haven't as yet, I don't think, been really asked.

THE CHAIRMAN: As Mother Maillé said, we are planning for the future and expect these things would come about in it. What we are concerned about is what should be the objective, what should be the overall planning for the next ten or twenty years.

DR. PIERCEY: I think, Mr. Chairman, from the point of view of the philosophy of why we ask for this particular point, it is we would like to see much less distinction made between the mental patient with his mental illness and the one which has a physical illness. As you know in the general population today there still remains a certain stigma to a person that has been in a mental institution. We think that day should be past, and anything we can do to keep this distinction much less and to wipe it out, we as hospital people in the general field would be very happy about.

THE CHAIRMAN: I come to another point. We have represented as your recommendation 14: That hospitals should continue to operate schools of nursing. I am going to turn this over to Miss Girard in a moment. We have that representation in the long line, we ought to be looking to the day when the hospitals will leave, will forego or perhaps leave the schools of nursing field,







Martin 9448

because nursing is primarily an educational experience, and should be under the control of the educational authorities. I am paraphrasing what has been said. Your recommendation is that hospitals should continue. Would you want to expand on that?

MR. MARTIN: I think, Mr. Chairman, we approach this primarily in the sense that as things are going obviously the hospital schools would produce the greatest number of nurses.

THE CHAIRMAN: That is the accepted proposition, they produce all but a very small percentage of the nurses graduated from year to year.

MR. MARTIN: We have been prepared to admit in the brief that there are inadequacies in the setup as there will be in anything, but we believe that because of the peculiar nature of the relationship between the nurses and the hospitals that the system as it is presently instituted --- I would say we are not opposed in any way to the preparation of the nurses at the university level. We are, in fact, supporting it quite heartily. We do say there is still room for the hospital school, and there will be for a good long time to come as far as we are concerned, because of the situation that has already developed, because of the facilities that are already there, because of the fact that we believe the hospital school, because --- in the initial instance the hospital is primarily a public service institution and that the existing schools can be modified to keep up with the evolutions that will occur in the educational field as they will in the hospital





Martin 9449

field, that there are certain tangible assets to be considered in relation to the question of why the schools are connected with the hospitals now and the least of these, I submit, Mr. Chairman, is the question of recruitment. There has always been and we, of course, would be very loathe to trade something we know will work for something we are not sure will work.

THE CHAIRMAN: What you are saying is you are now producing nurses.

MR. MARTIN: That is right.







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4 MR. MARTIN: The question then becomes  
5 one, we are convinced, that in the question of recruitment  
6 alone there is a certain aura that a hospital medical  
7 centre set-up has about it that itself, I am sure,  
8 influences many other factors, influences people to  
9 take up nursing and we have had examples of this in  
10 certain other fields where schools of a type have  
11 attempted to be started and have not been too successful  
12 but put back into the hospital orbit, they immediately  
13 become successful.

14 As far as recruitment of people and  
15 individuals are concerned, this is an intangible, Mr.  
16 Chairman, as far as I am concerned. A difficult thing  
17 to explain specifically and I am sure it does have an  
18 aura for people coming to the hospital school; still  
19 has quite an attraction and is something that we  
20 cannot see quite duplicated in what you might call  
21 another educational setting, such as a technical school  
22 or something like this. It just wouldn't have the  
23 appeal, that is all, for the type of person, young  
24 person who presently is enrolled in the nursing schools.

25 MR. WESTBURY: If I might add sir  
26 to what Mr. Martin has said, I think we must not lose  
27 sight of the fact that the student nurse has to get  
28 her clinical training in the hospital. That is part  
29 of her training and for that reason alone we feel that  
30 hospitals should continue to operate the schools of  
nursing.

As Mr. Martin has said, we recognize  
there are certain administrative positions in nursing





Westbury

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4 that require a higher standard of education and to that  
5 extent we thoroughly agree with a degree course in the  
6 university.

7 Another aspect of it is a matter of  
8 finances on the part of the students. If they go to  
9 university, they have to pay university fees and support  
10 themselves. In my opinion, I think that would tend  
11 to reduce the numbers going into nursing, the limited  
12 availability of finances to pay her education. Whereas,  
13 in the hospitals, most hospitals provide board and  
14 lodging and do not charge a fee.

15 THE CHAIRMAN: May this question be  
16 put to you. If you are in a position to give any  
17 answer -- is the fact that a hospital operates a nursing  
18 school, is that an asset? I mean an asset in terms  
19 of saving money?

20 MR. WESTBURY: To the hospital sir?

21 THE CHAIRMAN: To the hospital?

22 MR. WESTBURY: Many, many years ago  
23 sir, it might have been, but that is not the situation  
24 today. Today the student nurses in most of the larger  
25 hospitals have an eight-hour day, five days a week.  
26 Have time off, the same as the graduate nurses and the  
27 service that they give on the wards is limited to the  
28 need for clinical training.

29 I don't think hospitals, generally  
30 speaking, now exploit the student nurse.

COMMISSIONER McCUTCHEON: What happens  
when you run into some budget difficulties in your  
overall budget? Where do you cut back first? On quality







Westbury

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4 of training of the nurses or the quality of the care  
5 in the hospital?

6 MR. WESTBURY: Well, speaking personally,  
7 we go to the bank and try to borrow the money.

8 COMMISSIONER McCUTCHEON: You must be  
9 in a unique position.

10 MR. WESTBURY: I don't think that we  
11 are. Cut-backs on the training of the nurse would be  
12 the last that we would do. There may be certain,  
13 perhaps, refined services given in a hospital that have  
14 to be examined, if it came to that point.

15 I think under the Provincial law now,  
16 under the Acts they recognize that the cost of training  
17 the student nurse is part of the reimbursable cost and  
18 to that extent, we wouldn't have any budget cut-back.

19 COMMISSIONER McCUTCHEON: Up to a  
20 point.

21 MR. WESTBURY: Yes, except that I  
22 learned in one particular province, my own actually,  
23 they are taken into account, the number of student  
24 nurses in any particular hospital and cutting the budget  
25 accordingly. That is a fight we have with them at the  
26 moment.

27 COMMISSIONER McCUTCHEON: The  
28 suggestion has been made -- I am paraphrasing now --  
29 in a number of places certainly you can't abandon the  
30 hospital nursing schools tomorrow morning. You would  
have no nurses. It is also recognized that you must have  
hospitals available, and preferably the larger teaching  
hospitals in which the nurse students would obtain their





Westbury

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4 clinical training and that there should be a separation  
5 of the function of administering the hospital and  
6 caring for the people in the hospital from the function  
7 of educating nurses and that there should be separate  
8 budgets for that purpose so that there is a complete  
9 independence and there is no danger -- you don't get  
10 into the danger of dual positions of maybe leaning on  
11 your student nurses a little more than you should when  
12 the budgets are tight, and so on.

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14 Now have you any comment to make as  
15 to that?

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17 MR. WESTBURY: My only comment would  
18 be that in most of the larger hospitals we are gradually  
19 working towards that.

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21 MR. MARTIN: I think Mr. Chairman this  
22 is what we mean in the evolutionary process. There is  
23 no question about it with the introduction of hospital  
24 insurance, the hospital insurance plan has, as a rule,  
25 made possible the much more proper financing of a number of  
26 activities of the hospitals because there have been  
27 certain financial burdens which hospitals have traditionally  
28 carried over the years which have been a problem to them.  
29 Many of the hospitals have had a short duration of this.

30  
31 As I say, we do not say that the  
32 hospital school will be the only school. That is not  
33 what we are saying. We do say that there is a place,  
34 a definite place in the hospital school for the education  
35 of nurses and in the evolutionary processes which are  
36 taking place that the level of the program in the schools  
37 will move up, and I think we have to depend on our ability







Westbury

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4 to obtain qualified staff, good instructors, and so  
5 on, and in this process the hospital schools will measure  
6 up, should measure up as a good place for the education  
7 of the nurse.

8 COMMISSIONER BALTZAN: Hasn't that  
9 been actually the case over the past several years?  
10 That hospitals schools have almost, year by year, pro-  
11 gressed? Curricula have been improved, the working  
12 time for the nurses has been properly arranged in  
13 relation to the clinical, didactic, and other things?  
14 If one compares things as they stand today in these  
15 traditional schools with things ten years ago, or  
16 twenty years ago, very definitely a noticeable, pro-  
17 gressive improvement.

18 We are not talking about the system  
19 that prevailed 20 years ago. We are talking about the  
20 system today and compared with, say, a decade or two  
21 ago there has been progress, or hasn't there?

22 MR. MARTIN: We would like to think  
23 so sir.

24 COMMISSIONER BALTZAN: I haven't any  
25 doubt myself.

26 COMMISSIONER McCUTCHEON: You are going  
27 one further step in suggesting that the improvement  
28 will continue to the point where the hospital schools  
29 will attain the standards which the Canadian Nurses'  
30 Association would like to see all nursing schools  
attain?

MR. MARTIN: As an Association, Mr.  
Chairman, we are on record in several ways in that regard,





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4 and certainly this would be an objective that we would  
5 be encouraging our members to strive to.

6 COMMISSIONER VAN WART: Are the  
7 schools training the nursing assistants, training  
8 adequate number of nursing assistants at your hospitals?  
9 Is there a shortage, in other words, of nursing assistants  
10 in your hospital plan?

11 MR. MARTIN: I think it is acknowledged  
12 that there is a shortage, yes, of various types of  
13 personnel.

14 I find difficulty again in answering  
15 your question, Dr. Van Wart, specifically, because of  
16 the difficulty in trying to assess ten Provincial  
17 set-ups here as against the -- you can speak specifically  
18 to one or more, but you are not sure of the rest. As  
19 a general rule our members still seem to feel there are  
20 shortages. That there aren't enough --- there are  
21 problems of staff that they will need extra people,  
22 trained people.

23 COMMISSIONER VAN WART: Is there a  
24 feeling that you need more of these institutions to train  
25 these people, or do you think they can handle the  
26 training of nursing assistants under the facilities that  
27 they have and turn out an adequate number of them?

28 MR. WESTBURY: A number of the larger  
29 hospitals are establishing schools for nursing assistants  
30 and giving a one-year course in the nature of a practical  
nurse, one might say. Many of the functions which the  
graduate nurse, the minor functions which the graduate  
nurse now does can be done by nursing assistants. There







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4 is a tendency for most of the larger schools to adopt  
5 this system now. Quite a number of them have introduced  
6 this quite recently.

7 COMMISSIONER GIRARD: Mr. Chairman, I  
8 thought I was going to be quiet today and let this be  
9 a hospital administrators' day, but I think I will only  
10 ask one question in two parts.

11 A few minutes ago, Mr. Martin, you  
12 said that you would like to see the schools of nursing  
13 in the orbit of the hospital, so my two questions are  
14 one: Do you feel that the Florence Nightingale School  
15 is in the orbit of the hospital? Two: Would you be  
16 in favour of this type of school, generalizing?

17 MR. MARTIN: Obviously, the Nightingale  
18 School is, I would say, another very useful and  
19 practical approach to the question of nurses' education.  
20 I think I would answer you by saying, in my opinion,  
21 there is room for all of these various types of school.  
22 The Nightingale School is a school that is not directly  
23 in the orbit of the hospital, but it definitely has a  
24 very definite hospital tie-in. These differences, in  
25 my opinion, as an individual -- I will speak now as an  
26 individual, taking myself out of the position of the  
27 Canadian Hospital Association. These are matters of  
28 a variation of degree, and I think you can draw some  
29 close parallel with the evolutionary process. A number  
30 of other schools that are maybe hospital schools now  
could slide very easily over a line and become very  
similar to what you are referring to as the Nightingale  
School so that it is very difficult to either be for or





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4 against, specifically, one form or other of this because  
5 all of these, in my opinion, have definite places in  
6 the on-going processes that are being worked out here  
7 and the eventual test of this will be the ones that  
8 stand up.

9 I think this is, in the way I look at  
10 it, I see no conflict here with the Nightingale School  
11 and the pure hospital school. They are a slightly  
12 different concept but time could bring these concepts  
13 much closer together.

14 COMMISSIONER GIRARD: If the schools  
15 developed along this line, you would not be opposed to  
16 it?

17 MR. MARTIN: I would not be opposed  
18 to anything that eventually will produce, in sufficient  
19 quantity, the quality of the product that is desirable  
20 to look after the care of the sick people of this  
21 country.

22 COMMISSIONER GIRARD: You see, when  
23 the nursing profession speaks about independent schools,  
24 we also feel that with an independent school that there  
25 can be a lot of modes. I don't think we are still saying  
26 that it has to be just one type.

27 This technical school idea was brought  
28 up, but I don't think anyone has very definite ideas  
29 yet on that, but this is one type of school that was  
30 considered and the idea of the independent school is  
one of the ideas that is being considered, and if you  
are not opposed to the idea of a school along the line  
of the Nightingale School well then you probably wouldn't







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be opposed to the idea of the schools that we have in mind also.

If you accept one you would probably be pretty near to accepting the other.

MR. MARTIN: Except that we come back to where we see a vital place for the hospital school of nursing, or the school of nursing closely connected with the hospital.

COMMISSIONER GIRARD: "Wherever the school would be the hospital facilities would have to be used anyhow. I mean I feel that we would still be in the orbit of the hospital, let's say, even with a technical school. Not that I am saying it should be a technical school, mind you, but even if we do take the idea of a technical school, the technical clinical experience would still be in hospital. You can't get the technical experience outside of the hospital.

The student nurse has to be given the patients to be able to get her experience, so that I think we are more or less speaking the same language.

There is a great deal hinges on terminology. I think we are thinking along the same lines, pretty much. If we can get our thinking adjusted, if the two groups can get the thinking adjusted, I think that this is a matter of doing it gradually, and I don't think we are so far apart in these theories.





Westbury

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MR. WESTBURY: Would your school still be subject to the responsibility of the Board of Governors of the hospital and controlled by them or controlled as an independent body?

COMMISSIONER GIRARD: This would have to be looked into but if you mean should it be subject to the Board of the hospital, that is the one thing we would fear. In a shortage of graduate nurses you would naturally revert to the school to fill in the gaps; that is what we do now, we have to be honest about it, Mr. Westbury; you do it and we do it now. This is what we want to get away from. We want to get away from the hospitals using the students to fill the gaps of the graduate nurses or the person that is not there. If we want the school to be an educational institution you do not pull students out of the classroom to bring her in to do some work because that profession happens to be short of people. We would like the nurse to be in the same category as the others and when they are too easily accessible - who said the inevitable accessibility of the student nurses? - somebody said that and it is so true.

When they are so easily accessible there is a danger you will pull them out of their school work, their educational process, to bring them in to fill the gaps. This is what we are afraid of and these are the things we are complaining about.

I think these other things you understand as well as we do and you feel the same way we do. You say you want the school to be an educational institution and I believe you do as much as we do but if the student







Maillé

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is there there is the inevitable accessibility.

MOTHER MAILLÉ: I think that in the present set-up of schools going with a hospital I can say right now you should not be afraid that we are using nurses except for what they have to learn for their own experience. If we see how many hours that nurses are in the hospital right now we can see that there is a very large difference through the years. We are not against the new formula but it is true that the present formula can be for the benefit of the students.

I would like to add too about spirit, that we like very much to point out that it is true that the training in hospital, as we have now, three years or four years course if you are going further, there is a special spirit because they are part of your organization and it is very different and we can see the difference because many years ago we had experience with some technical classes different from nurses and we can see the difference.

We are not only producing nurses but I think right now we can say we are producing good nurses and it is very important to have good nurses with good standards and a really good education.

COMMISSIONER GIRARD: Except, Mother Maillé, according to a lot of magazines and newspaper articles here and there, we do not seem to be producing good nurses. If you read one of the big magazines last month and there are a lot of articles like that coming out, the public does not feel we are producing good nurses any more.





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4 THE CHAIRMAN: Well, I would like to  
5 make a comment on that. We have been in ten provinces  
6 and by this time we have heard some 250 organizations  
7 and not one has said a word about the quality of the  
8 nurse adversely; nobody has said we are not producing  
9 an A.1 nurse in Canada. We are told they are welcome  
10 in places all over the world and they are coming across  
11 the line, across the border, and stealing them from us  
12 high, wide and handsome because they are well-trained.

13 I do not pay too much attention to what  
14 you sometimes read in magazines or newspapers.

15 MR. MARTIN: I think that is true, it  
16 is not what is good about anything that sells it, it is  
17 the sensational aspects that will sell a publication.

18 DR. PIERCEY: I think in paragraph 14  
19 we would want to re-emphasize that in making this  
20 submission we are not asking to be the only place to  
21 produce professional nurses. We recognize at the moment  
22 there is a great need to have more people in the univer-  
23 sity courses and there is a very definite need to have  
24 this type of trained person. We would not want anybody  
25 to construe that this recommendation of ours in any way  
26 is deprecating the fine work done in university courses  
27 because we need this type of individual in our hospitals.

28 COMMISSIONER STRACHAN: Mr. Chairman,  
29 recognizing the fact that we have members of our society  
30 such as retarded children and those with hare lip and  
cleft palate who require hospital accommodation generally  
under general anaesthesia, has your Association any  
policy to encourage the development or establishment of







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dental clinics in hospitals?

MR. MARTIN: I think, Mr. Chairman, that this again comes back to proposed planning functions. It seems to me that wherever, as I recall, any of the studies that have been done, this aspect of the public health problem has received attention; the oral, the dental needs of children particularly has been recognized as a problem and a special study is and has been given to this particular problem. As an Association we have not developed any stated policy in regard thereto but again, it would seem to me it is very definitely a part of the local planning considerations.

COMMISSIONER STRACHAN: But you do encourage your provincial organizations along certain lines, I am sure. Have you not any policy in this respect at all or can you report any progress - are you aware of any progress along this line during the past few years or could you see any immediate results in the future?

MR. WESTBURY: I would say in the larger medical schools this situation is well-recognized. We know plastic surgery has advanced considerably in most of the larger hospitals and certainly dental clinics are encouraged. I think it is a matter for the individual hospital to decide rather than the province to state a policy.

COMMISSIONER STRACHAN: I am only asking whether you are doing anything to encourage it.

MR. WESTBURY: As an Association we are not but we would support and encourage it.





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MR. MARTIN: Indirectly, as we are a very ardent supporter of the Council of the Accreditation of the Hospitals, there has been discussion in various departments and in this way we would be lending support to that development.

MR. McCracken: In our recommendation for an original concept of hospitals the original hospital and the teaching hospital, we do mention that these hospitals should provide dental services. These dental services should be an integral part of the hospital and I think we state on page 81:

"A dental service, affording experience in all the specialty branches such as oral surgery, prosthetics, orthodontia, etc., should be provided to offer a complete educational program as well as to meet the needs of cases requiring such services."

I do not know if that answers your question or not.

COMMISSIONER STRACHAN: Thank you very much.

COMMISSIONER VAN WART: In recommendation No. 4 you recommend more assistance for convalescent facilities. Has consideration been given to the addition of a convalescent wing to the acute general hospital to relieve your chronics needing rehabilitative care and so on?

MR. WESTBURY: I think that perhaps the answer to your question is that the concept now is that







Westbury

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chronic hospitals and convalescent hospitals should be in the vicinity of the acute hospitals, if not part of the acute hospital itself. We have found from experience that when they are built in the country, the chronic and convalescent, that the patients are very much disturbed because the visitors do not come to see them because it was too far away or they could not afford to come. There is a tendency now that this type of hospital be built in the general location of the general hospital and, in many cases, operated by the general hospital and some hospitals are installing convalescent and rehabilitative wards.

COMMISSIONER VAN WART: They can have the facilities of the acute hospital, the medical staff?

MR. WESTBURY: That is right.

COMMISSIONER VAN WART: Under one roof.

MR. WESTBURY: And you have to be prepared if a chronic patient has a remission or flare-up you have to get that patient into the general hospital as quickly as possible.

COMMISSIONER VAN WART: Then, Recommendation 16, is that recommendation put in through fear that another government scheme would drain off funds from hospital funds?

MR. WESTBURY: We always have that fear and it is our feeling that if any additional benefits are introduced that are going to cost money it should be paid for by additional money and not by utilization of present money and divert that money from the use to which it is now being put.





Martin

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COMMISSIONER FIRESTONE: Mr. Martin,  
in Recommendation 4 on page 1, you say:

"...the present hospital construction  
grant program be amended to provide  
more generous grant assistance for the  
construction of facilities..."

What increase do you have in mind?

MR. MARTIN: It would seem, Mr. Chairman,  
that with the present grant structure being parallel  
for all types of accommodation that the construction of  
the convalescent and rehabilitation or other facilities  
does not have the same glamour, shall we say, to use the  
word of the street, as the others do so priming processes  
could best be served by if the federal grant program was  
so arranged that there be perhaps two or three times as  
much given for this type of facility to encourage the  
construction of this vis-a-vis the acute general hospital  
care.

In the grant formulas as originally  
laid down by the Federal Government there was a differentia-  
tion of about \$500, \$1,000 for general and \$1,500 for  
the other type and this disappeared when there was an  
increase to \$2,000. Rather than have it disappear we  
feel it should have been broadened at that point.

COMMISSIONER FIRESTONE: Assuming that  
such a recommendation of yours were accepted which would  
only deal with the situation in existence at the present  
but as Mother Maillé said, we are planning for the future,  
can you visualize a grant formula which would take account  
not only of the existing situation but of changes over a







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3 period of time, say, increase in construction costs, etc.?  
4 Have you given consideration as to what kind of formula  
5 the Canadian Government might consider for adoption to  
6 deal not only with the situation today but to deal with  
7 the situations as they developed? If you have not given  
8 that study would it be too much to ask you to have your  
9 Executive consider such a formula and make it available  
10 to us as your recommendation?  
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MR. MARTIN: I think I would say to you that we have given consideration to it, but that we were not able to bring down something that was generally acceptable to everyone by the date of this hearing. But we would be glad to continue these researches in this connection and let you have the benefit of what we come up with.

COMMISSIONER FIRESTONE: We would be very grateful if this Commission were to get from you some advice on this point. We would like to have the best recommendation we can obtain from your Association, and perhaps your deliberations can be summarized and the reasons for them given in the form of a written recommendation to our Secretary in the next several months, if it is convenient to you.

MR. MARTIN: We will certainly do our best for you, Mr. Commissioner.

COMMISSIONER FIRESTONE: Thank you very much. I now turn to recommendation 10 on Page 2, in which you say:

"That the present method of financing medical research in hospitals by means of grants be continued and such funds be substantially increased."

Increased by how much?

MR. MARTIN: Again, I would think this would be a matter of degree, Mr. Chairman, through you, Professor Firestone. We didn't have, nor anywhere have we got yet an accurate estimate of actually what they are now. We know there are numbers of areas where money could be used. We said "substantially" because we were







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aware in our researches that there were areas which we were unable to cover. We haven't got a specific answer to that.

COMMISSIONER FIRESTONE: Mr. Martin, we are here to advise the Federal Government, and presumably it would be possible for your Association to obtain from the Department of National Health and Welfare the figures relating to the amounts that the Federal Government at the present time spends on research and for the purposes indicated in your Paragraph 10, that having obtained that amount you could say this is inadequate, we recommend you increase it by 50% over the next year or two and by 100% over the next five years, and give your reasons why you feel this is necessary.

Would it be possible to ask you to undertake this little bit of extra work to give us a little guidance as to the meaning of your recommendation in Paragraph 10?

MR. MARTIN: We will try to do something specific on it, Mr. Chairman. I wouldn't like the significance to be lost in terms of dollars, but what we were recommending is that you don't fall back to the hospital insurance plan costs. That was the important part of our recommendation.

COMMISSIONER FIRESTONE: That is the principle, but when you apply the principle you want to tell us how much and how it would be covered. Would you try and cover that now in your recommendation?

MR. MARTIN: Yes.

COMMISSIONER FIRESTONE: Paragraph 12,





Martin 9469

on Page 3. You recommend:

"That grants be made available to facilitate studies of the need for and utilization of medical, paramedical and nursing personnel in hospitals."

If such grants were made, how would you undertake such studies?

MR. MARTIN: On Page 42 of the brief, Mr. Chairman, we do say in Section 91:

"Pilot activity studies should be undertaken by the hospitals in cooperation with professional associations and Government departments for the purpose of determining ..."

I think this sums up our position.

COMMISSIONER FIRESTONE: I read that paragraph, and I wasn't quite sure when you say "cooperation." Would it be under the direction of the hospitals or to set up a team of researchers? How would it work? Who would be responsible? I am trying to think of the grants being made to somebody and spending the money and producing the results. Who would be responsible?

MR. MARTIN: I think, Mr. Chairman, what could be said is that what we had in mind was the national groups, probably, the national groups of the various people concerned in this. Work has been done in cooperation with Provincial departments before, so we would not be averse to working with a Provincial Government, Federal Government or those people directly concerned in the results of the studies that are being effected.

COMMISSIONER FIRESTONE: In other words, you are saying you are all for cooperative effort, and







Martin 9470

that is a very laudable attitude. But somebody has to say this money is for this purpose, please say how it is to be done. To whom would it be given?

MR. MARTIN: I could visualize this might be given to a specific hospital where a specific study could be done. It could be given to one of the associations who would act as the agent responsible for production of the studies.

COMMISSIONER FIRESTONE: When you talk of associations, what associations do you have in mind?

MR. MARTIN: At this point I am thinking of the one that I am sitting representing here, Canadian Hospital Association, the Canadian Nurses' Association, the Canadian Medical Association, and all the groups who are vitally interested.

COMMISSIONER FIRESTONE: May I turn to Paragraph 16, Sub-paragraph (a), on Page 4 of your recommendations. You say:

"No health care plan more comprehensive than that which now exists should be introduced until it can be adequately financed without detracting from present health services."

What do you mean when you speak of "without detracting from present health services"?

MR. MARTIN: As the Chairman has intimated, we are already embarked in this country on quite an extensive program of hospital insurance. There are a number of programs in the health field that are being provided with funds from Government sources at the





Martin 9471

present time, and we are aware of programs that are already in operation, Professor Firestone.

COMMISSIONER FIRESTONE: I understand there have been suggestions made that some programs that are already in existence could be improved. For example, we were talking about mental health.

MR. MARTIN: Mental health, that is right.

COMMISSIONER FIRESTONE: One might visualize Governments might save money on mental institutions and spend it on building or expanding extra wards in general hospitals. Do I understand that this is a so-called flexible recommendation, that where it makes sense to cut back some programs and substitute them by more efficient programs, that that would be included in your recommendation?

MR. MARTIN: Providing the quality of the existing programs is not detracted from. We realized as soon as we became involved with Government financing we were in competition with roads, in competition with all sorts of services, etcetera, and just as budgets can be fluctuated in hospitals, we believe that they can be fluctuated in Government projects. So we would hate to see any halt in the health programs.

COMMISSIONER FIRESTONE: Your objective would be to work on the further improvement in the quality and comprehensiveness of health care services provided in Canada. That is your objective?

MR. MARTIN: Yes.

COMMISSIONER FIRESTONE: Thank you







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very much. May I now turn to Paragraph 58 on Page 30? I was very much impressed, I may say, with your emphasis on the role of the hospital in the field of preventive medicine. I think this is a very forward-looking proposal, and I personally welcome this. I would just like to understand one part of the recommendation. You say you visualize "mass screening of the well to detect unsuspected diseases." Would this mass screening of the well work in practice?

DR. PIERCEY: I think, Mr. Chairman, we visualized, as an example, we have had for a number of years in Canada now the admission chest X-ray. There are a number of voluntary organizations who do mass X-ray to detect diabetics. There is one where, on a Provincial basis, they are setting up very shortly facilities for mass screening, early detection of cancer. It is in this role that the hospital in the future has even a more important role to play.

COMMISSIONER FIRESTONE: And it would be extended through out-patient facilities?

DR. PIERCEY: Yes, in the term of the ambulatory facility. I am trying to make the distinction between the out-patient clinic; there is the more or less ambulatory out-patient clinic.

COMMISSIONER FIRESTONE: Thank you very much. May I now turn to Paragraph 194 on Page 82 where you recommend or suggest that "it would be highly desirable if the out-patient services of these hospitals can be closely tied in with the public health activities of the local health department units..." Now, how would





Piercey 9473

this tie-in work in practice?

DR. PIERCEY: Mr. Chairman, in some of the smaller hospitals in the west we do see this developing now as a close liaison between the local health medical officer and his department and the hospital. I think the intent would be to say that there is some duplication between voluntary agencies, department of health, local departments of health, and I think we were speaking here of what we feel is a need for some better coordination between these various groups that are in this field.

COMMISSIONER FIRESTONE: How would you achieve it?

DR. PIERCEY: Well, here again I think it is often a matter of more cooperation. It comes back to this planning thing we talked about. If you get people around a table, at least they talk to each other, and something of a cooperative nature may come out of it, we hope. Sometimes we don't talk enough to other agencies who are vitally concerned in the health field.

COMMISSIONER FIRESTONE: I was just going to say or inquire whether people in the field really do not talk to each other?

DR. PIERCEY: I would hope they do. We do talk, but I don't think we talk enough.





Page 8473

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of the smaller hospitals in the west we do see this

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ment of health, local departments of health, and I think  
we were a long time of what we feel as a need for some  
better coordination between these various groups that  
are in this field

COMMISSIONER: Now would you

believe it?

MR. LEBRON: Well, here again I think

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agencies who are vitally concerned in the health field.

COMMISSIONER: Now, I was just

MR. LEBRON: I would hope they are



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4 COMMISSIONER FIRESTONE: Thank you  
5 for that comment, sir. My last question, sir, deals  
6 with the drug distribution in hospitals. Do hospitals  
7 across Canada, particularly the hospitals of a certain  
8 size employ pharmacists, I am thinking now of public  
9 hospitals?

10 DR. PIERCEY: They do.

11 COMMISSIONER FIRESTONE: What size  
12 hospital?

13 DR. PIERCEY: I think there would be  
14 very few, Professor Firestone, under 50 to 60 beds.

15 COMMISSIONER FIRESTONE: Over 50  
16 beds in most hospitals they have full-time pharmacists  
17 and 50 beds and under part-time pharmacists?

18 DR. PIERCEY: That is about it. I  
19 think in the smaller hospital the very usual practice  
20 is to utilize the facilities of a pharmacist practising  
21 in the community.

22 COMMISSIONER FIRESTONE: Now, sir,  
23 how do hospitals make available drugs, and I am referring  
24 to prescribed drugs, to persons visiting out-patient  
25 clinics?

26 DR. PIERCEY: How do they make them  
27 available?

28 COMMISSIONER FIRESTONE: The patient  
29 visits the clinic and the doctor prescribes a drug.  
30 Does he pay for it. Does he get it free if he is  
medically indigent. How does this system work?

MR. WESTBURY: I think in most cases,  
in most hospitals it is done by means tests according to





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4 the patient's ability to pay as to whether they pay the  
5 cost price or it is shaded down to what they can afford  
6 to pay for these drugs in the larger hospitals.

7 COMMISSIONER FIRESTONE: Therefore,  
8 if somebody visits the clinic and he is in a position  
9 to pay he will pay for the drugs he has received for  
10 the cost price as determined by the hospital?

11 MR. WESTBURY: That is right, sir.

12 COMMISSIONER FIRESTONE: And then, if  
13 he is either indigent or medically indigent and if he  
14 can only pay a part he may be paying a part, or if he  
15 is completely indigent he may be given the drug free.

16 MR. WESTBURY: This is true.

17 COMMISSIONER FIRESTONE: If somebody  
18 is visiting a clinic and he has been in the position to  
19 pay for the drugs fully, and he has paid, we have been  
20 told that hospitals are in a position to purchase drugs  
21 at a considerably lower cost to them than local retail  
22 pharmacists, and therefore this man having paid for his  
23 drugs, having visited the out-patient clinic, will have  
24 paid a considerably smaller amount or may have paid a  
25 considerably smaller amount than he would have paid if  
26 he had visited the local drug store?

27 MR. WESTBURY: That is possible, yes  
28 sir.

29 COMMISSIONER FIRESTONE: Would you say  
30 from your experience that as a rule, and generally  
speaking, there may be some exceptions, but speaking  
generally the hospitals are able to purchase drugs at  
considerably lower cost than retail pharmacists?





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one person's ability to do as much as the other two. The  
cost price of it is not down to what they can afford  
to pay for this in the market.

It is not only the price and the position  
of the goods, but the price he has received for  
the cost price as determined by the market.

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of the goods, but the price he has received for  
the cost price as determined by the market.



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MR. WESTBURY: I don't think that is quite true, sir. I think it depends on the quantity. The more you buy the cheaper you can buy them, and the larger hospitals buy in huge quantities and get a price discount accordingly. I don't think that the pharmaceutical houses discriminate in favour of the hospital as against a wholesale distributors.

COMMISSIONER FIRESTONE: We have had evidence to the contrary submitted to us. We will have an opportunity to pursue the subject further when we have the drug manufacturers appear before us. The point remains, that even on the basis of your admission that in many instances the hospitals will be able to purchase the drugs at considerably or noticeably lower prices or cost than the retail pharmacist.

MR. WESTBURY: On a lower unit cost.

COMMISSIONER FIRESTONE: At a lower unit cost, that is correct.

MR. WESTBURY: That is right.

COMMISSIONER FIRESTONE: Now, the question arises whether hospitals could expand their facilities which they now provide of making drugs available to out-patients, those that can pay at lower prices, lower cost to people that are out-patients, to those visiting their clinic, drug prescriptions made out by duly licensed physicians? What would stand in the way of hospitals in Canada expanding their facilities to sell drugs to everybody that came in with duly filled out prescriptions by a physician?

MR. WESTBURY: I would be interested to





Westbury

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4 hear what the Canadian Pharmaceutical Manufacturers  
5 would say to such a thing.

6 COMMISSIONER FIRESTONE: I will ask  
7 them that question.

8 MR. WESTBURY: I think they object now  
9 to the fact that hospitals do follow this practice. The  
10 hospitals have one particular problem. It is recognized  
11 that out-patient clinics are staffed to a large per cent  
12 by interns and residents, none of whom have licences  
13 to practise outside the hospitals and therefore the  
14 retail druggist could not accept the prescribed signed  
15 by the intern, but it can be accepted in a hospital.  
16 Some hospitals have seriously been considering whether  
17 or not they should send all the prescriptions, all the  
18 patients with prescriptions, the patients that are able  
19 to pay for their prescriptions to outside retail druggists  
20 to have it filled. Because of the problem of no licences  
21 we haven't been able to do it.

22 COMMISSIONER FIRESTONE: That wasn't  
23 quite my question.

24 MR. WESTBURY: You are thinking the  
25 other way.

26 COMMISSIONER FIRESTONE: Yes, exactly.  
27 It was the other way around. Mr. Martin, Mother  
28 Maille, gentlemen, if a patient goes to his physician,  
29 gets a prescription for drugs, the patient could go to  
30 a pharmacy attached to a hospital and purchase these  
drugs at a considerably lower price than he could  
purchase them from the retail pharmacist because of the  
mass buying facilities and, perhaps, for some other







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3 reasons which we don't want to examine here. We will  
4 discuss them with the drug people and the pharmacists.  
5 If I may just finish the question, my question is would  
6 that be possible for the hospitals to provide such  
7 facilities employing duly qualified pharmacists?

8 MR. MARTIN: I think, Mr. Chairman,  
9 you would have to put this in focus, and your hospital  
10 pharmacies are primarily set up to serve hospital  
11 patients. As I understand your question, Professor  
12 Firestone, this patient wouldn't necessarily be a patient  
13 of the hospital. They might be a patient of a private  
14 physician somewhere, and I would think this is not the  
15 role that the hospital is designed at the moment to  
16 fulfil. These pharmacies are primarily there to provide  
17 drugs to the patients that are in bed, or the patient  
18 that comes from the clinic or the private services that  
19 are in the hospital. They are not designed to provide  
20 drugs to the community as a whole.

21 COMMISSIONER FIRESTONE: You are quite  
22 right, the present purpose of the hospital pharmacy is  
23 to look after the needs of either in or out-patients,  
24 but treated by the hospital. In providing this service  
25 you are providing drugs to those who benefit from this  
26 arrangement at a lower price than the rest of the  
27 community, and the question arises: Why could these bene-  
28 fits not be extended to the rest of the community and  
29 give everybody lower drug costs?

30 MR. MARTIN: Wouldn't it be better to  
give a lower cost to the community drug store and have  
them provide that to the community?





Martin

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4 COMMISSIONER FIRESTONE: That is a  
5 fair suggestion if this could be worked out.

6 MR. MARTIN: I don't see it primarily  
7 as a hospital service. I don't see this suggestion of  
8 yours as a hospital service. It is a community service  
9 granted, but this community service could be provided  
10 equally by persons equipped and closer to the people  
11 rather than shuttle them from ten miles to the hospital.

12 COMMISSIONER FIRESTONE: If this  
13 could be done, I think this would meet the need. In  
14 case it can't be done ....

15 THE CHAIRMAN: What answer can anybody  
16 give you that you haven't had already?

17 COMMISSIONER FIRESTONE: I was just  
18 going to finish.

19 THE CHAIRMAN: Professor Firestone,  
20 we are just discussing certain .....

21 COMMISSIONER BALTZAN: It might be a  
22 good idea if everybody went into the wholesale business.

23 COMMISSIONER FIRESTONE: You were  
24 discussing the question of the hospital performing  
25 increasing community functions. Did I understand that  
26 recommendation properly? What we are talking about is  
27 this might be an extension of such community functions  
28 if they couldn't be provided otherwise.

29 MR. WEBER: I don't think it is a  
30 practical method of distribution. For one thing if  
people went to the Toronto General, where would they  
park to pick up the drugs. I think it is a community  
matter of distribution. I don't think this is a practical







Weber

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method of distribution.

COMMISSIONER FIRESTONE: It may well be it may have to be supplemented by other ways and means.

THE CHAIRMAN: Provide parking lots?

MR. MARTIN: May I say, Professor, that I would think all things are possible, but there are certain things that I would not say are desirable in the normal flow of business practice. That would be I think our answer to you, this wasn't our purpose in life. All things are possible, anything is possible.

COMMISSIONER FIRESTONE: You have been very helpful, gentlemen, and Mother Maille. Thank you very much.

THE CHAIRMAN: Dr. Baltzan?

COMMISSIONER BALTZAN: Mr. Martin, Reverend Mother and gentlemen, please be patient and let me deal slowly with this because I want to be satisfied on a few points. Let me begin, by telling you I consider your submission is an excellent document and it covers most of the points I could personally think of. Therefore, I shouldn't have any questions, however, when I read five or six times out of sixteen paragraphs in your first pages the word "amended", the operation of the Act appears to be a less than an exemplary model in those things which are intended for all plans. That is the way it appears to me. People generally definitely welcome hospitalization, we have heard that everywhere. What is your position? Is this form of hospitalization equally welcome and acceptable to





Martin

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3 you as administrators and people who run the hospitals?

4 MR. MARTIN: I think we covered that  
5 earlier.

6 COMMISSIONER BALTZAN: Then I didn't  
7 listen too closely.

8 MR. MARTIN: We said we felt that it  
9 had been accepted and there was no turning back.

10 COMMISSIONER BALTZAN: I am sure you  
11 have accepted it. Do you find it restricting? In other  
12 words, are you better off now than you were before in  
13 your hospital operations in relation, say, to the  
14 element that arises in connection with expansion,  
15 renovation, acquiring equipment, changing internal  
16 policies, systems of action and budgeting et cetera?

17 MR. MARTIN: I think I said earlier  
18 that obviously the introduction of hospital insurance  
19 cleared up a number of long outstanding problems. It  
20 did put definite financing on hospitals. I am speaking  
21 generally now, because I have qualified, there are  
22 certain variances by provinces because these are ten  
23 different plans really that we have and it is very  
24 hard to talk about them in a global way. Basically,  
25 most hospitals have found it easier for their financing,  
26 their general financing of operation and in this sense,  
27 obviously, attention can be then given to other things  
28 where people who are serving as trustees and administrators  
29 are not so vitally concerned on a day-to-day basis with  
30 exactly where their dollars are coming from. They can  
turn their attention to other things which have needed  
attention. Therefore, we feel the quality of hospital







Martin

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4 care will improve in the set-up now just so long as there  
5 is an expanding and a coming back to our recommendation  
6 Professor Firestone drew attention to, that there will  
7 be a guarantee of adequate financing on a continuing  
8 basis for the operation of the hospital.

9 COMMISSIONER BALTZAN: For these things  
10 that you have turned your attention to, have you the  
11 opportunities of fulfilling these requirements?

12 MR. MARTIN: Yes.

13 COMMISSIONER BALTZAN: Are you hindered?

14 MR. MARTIN: They are coming into  
15 focus now. Are we hindered, sir?

16 COMMISSIONER BALTZAN: Yes.

17 MR. MARTIN: No, I wouldn't say we  
18 are, no.

19 COMMISSIONER BALTZAN: You said earlier,  
20 and it is generally known that hospital services are  
21 available. Are hospital beds always available, or to  
22 what extent are they not available in terms of need?  
23 You are representing the Canadian Hospital Association.  
24 Is the question of availability and the question of  
25 meeting the demand, generally speaking is it greater  
26 utilization of hospital beds?





Martin

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MR. MARTIN: There has been greater utilization of hospitals with the introduction of hospital insurance.

COMMISSIONER BALTZAN: Do you find it more difficult to meet that supply?

MR. MARTIN: Yes. In certain areas, yes.

COMMISSIONER BALTZAN: To what extent will the detached hospitals, that have been referred to earlier, classes of the detached hospitals, disrupt patient care on the daily ward rounds in your operation of the hospital?

Now, I mean I have heard this is well-integrated with the daily ward operation, and when you have a group of visitors - a visiting group for clinical instruction, would you have to change your ward operations for the days when these classes come for their clinical instruction? Will it materially change your system?

MR. WESTBURY: No, sir. It will help us because beds are now being occupied by patients who are chronic patients, and one of our recommendations is that more beds be made available for rehabilitative and convalescent cases. Acute hospital beds are now being occupied by these cases that could be transferred to other institutions or hospitals to take care of that particular type of patient.

To that extent, when these beds are released, then we can take in more acute cases and it should enhance the teaching on the ward rounds.

COMMISSIONER BALTZAN: I have no doubt about that. I am talking in terms of daily ward







Westbury

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operations. We raise that question because that matter was brought to my attention in places that I had visited before.

MR. WESTBURY: Are you thinking, sir, of the fact that if we take more acute cases, we have to have more skilled nurses, and more skilled facilities?

COMMISSIONER BALTZAN: Not at all. I am thinking that now your classes coming over from your schools are well-integrated into your daily ward operations whereas under the new system, the detached schools, say, Wednesday morning, then you have to put your ward into a system of where now you are receiving this morning a group for surgical instruction, a group for medical instruction, etc., etc. Will this sort of thing change your form?

MR. WESTBURY: Yes, it would to some extent, sir.

COMMISSIONER BALTZAN: Will it be disrupting to medical care?

MR. WESTBURY: No. It wouldn't disrupt medical care.

COMMISSIONER BALTZAN: Thank you.

THE CHAIRMAN: Thank you very much, Mr. Martin and your associates and before you leave I think you might say from us to Judge Buchanan that we missed him this morning and also, if you are not too modest, say that it was ably represented by those who were here. Thank you.

MR. MARTIN: Thank you, Mr. Chairman. On behalf of the group we thank you for the reception





Martin

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that has been accorded us this morning.

THE CHAIRMAN: We will now take a short  
break before we go ahead with the Ontario Hospital  
Association.

--- Short Recess

THE SECRETARY: The next submission,  
Mr. Chairman, will be that of the Ontario Hospital  
Association and will be known as Exhibit 256. Mr. Wallace  
will present his group.

--- EXHIBIT NO. 256: Submission of the Ontario Hospital  
Association.

SUBMISSION OF THE ONTARIO HOSPITAL ASSOCIATION

Appearances: Mr. M.B. Wallace  
Mrs. J.A. Aylen  
Rev. Sister M. Janet  
Mr. P.A. Dick  
Mr. S.W. Martin  
Mr. H.G. Dillon

MR. WALLACE: Mr. Chief Justice, members  
of the Royal Commission on Health Services, my name is  
Wallace, W.a.l.l.a.c.e. My first name is Max. I am the  
President of the Ontario Hospital Association and I am  
employed as an administrator and Hospital Superintendent  
of the Toronto Western Hospital, a hospital here in  
Toronto with a little bit over 800 beds.

On my immediate right is Sister Janet,  
Vice-President of the Association and administrator of  
St. Michael's Hospital in Toronto, a hospital of over  
800 beds. On Sister Janet's right is Mr. Martin, the  
Executive-Secretary Treasurer of the Association.







Wallace

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On my immediate left is Mr. Harold Dillon, Administrative Assistant to Mr. Martin. Mrs. Aylen, past-President of the Association and a trustee of the Ottawa Civic Hospital. Far left, Mr. Proctor Dick, trustee of the Chatham Hospital and Chairman of our Executive Committee of the Ontario Hospital Association. This is not exactly the same as the chart we gave your Secretary, so that will be out.

THE CHAIRMAN: Mr. Wallace, if we might invite you to take a chair.

MR. WALLACE: Mr. Chairman, you must realize that we are to take the brief as read, and likely dwell on the summary of the conclusions and the recommendations. We feel, however, that it would be helpful to read paragraphs 1 to 6 in the brief as a preamble, and with your permission I would like to do that.

1. The Ontario Hospital Association, an incorporated voluntary lay organization, has been in existence since 1924. Its 240 members comprise public general hospitals, sanatoria, and special hospitals, with a relatively small number of private hospitals of associate member status. The Association thus embraces all categories of hospitals in the province with the exception of the provincial mental hospitals and the majority of the private institutions.

2. Membership in the Association is voluntary and is maintained on an annual fee basis. In return, a variety of consultative and advisory services is provided and a representation function is performed





Wallace

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of which this submission is indicative. The Association acts as the central voice of the voluntary hospital system in this province and to the extent that the problems and interests of a very diversified membership can be interpreted and condensed, every Association presentation of this type endeavours to reflect the point of view of member hospitals.

3. Certain highlights have marked the developing role of the Association. In 1941, supplementary letters patent were granted to enable the Association to inaugurate the Blue Cross Plan in the province which, at the height of its activity, provided \$65,000,000 benefits yearly to approximately 2,500,000 subscribers and dependents. With the enactment of the Hospital Services Commission Act and the inception of the hospital insurance plan on January 1, 1959, the Blue Cross Plan was precluded by statute from offering basic hospitalization up to the standard ward level. The Plan, however, has continued to make available semi-private accommodation benefits and, at the present time, over 2,000,000 residents of the province are enrolled. Extended health care benefits are also now available to employed groups.

4. The Association has maintained a close contact not only with the public hospitals of this province but with many thousands of citizens and patients over its 38 years. This relationship is exemplified in the makeup of its own board of directors wherein administrators (the chief executive officers of hospitals), superintendent and trustees (approximately 3,800 citizens who give of their time without recompense to serve on





at which this association is indicative. The Association acts as the central voice of the voluntary hospital system in this province and to the extent that the

3. Certain highlights have marked the developing role of the Association. In 1941, voluntary hospital plans were granted to enable the Association to inaugurate the Blue Cross Plan in the province. With the enactment of the Hospital Services Commission Act and the provision of the Hospital Insurance plan on January 1, 1950, the Blue Cross Plan was precluded by statute from offering basic hospitalization up to the standard ward level. The Plan, however, of the province are enrolled. Uninsured health care beneficiaries are also now available to employed groups.

4. The Association has maintained close contact not only with the public hospitals of this province but with many thousands of citizens and patients over its 35 years. This relationship is exemplified in the making of its own board of directors who are hospital trustees (the chief executive officers of hospitals).



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3 local hospital boards), are evenly represented. A  
4 further indication of this relationship is a valued  
5 liaison with the Women's Hospital Auxiliaries Associa-  
6 tion of Ontario, also a voluntary organization, whose  
7 70,000 members continue to make a noteworthy contribution  
8 both in material assistance and in understanding between  
9 our hospitals and the communities they serve. In addi-  
10 tion, the Association maintains a close liaison with  
11 the Ontario Conference of the Catholic Hospital Associa-  
12 tion and they have indicated to us support and endorsa-  
13 tion for the views expressed in this brief.

14 5. With such a background, the Associa-  
15 tion feels it is in a position to present an informed  
16 and responsible point of view and very much appreciates  
17 this opportunity of placing its resources at the disposal  
18 of the Royal Commission on Health Services on a matter  
19 so important to the future welfare of the citizens of  
20 this province.

21 RELATIONSHIP TO THE CANADIAN HOSPITAL ASSOCIATION

22 6. The Ontario Hospital Association  
23 is one of the constituent members of the Canadian Hospital  
24 Association whose brief we just listened to. The  
25 Canadian Hospital Association brief has endeavoured, of  
26 necessity, to take into account the variations that may  
27 be found in individual provinces, both as to philosophy  
28 and actual health care structure and operation -- that  
29 you will agree is a complex task. Without detracting  
30 from the principles advanced in the Canadian Hospital  
Association brief, the Ontario Hospital Association has  
deemed it important to comment on certain matters which





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may represent such a provincial variation but which, in any event, reflect this Association's point of view.

I will now read from the summary, which, if you want to follow me, is the page just following the index page, and it starts off:

1. Autonomy -

- a) As a general statement, the principle of self-determination at the local hospital level should be encouraged and preserved.
- b) Specifically, hospitals should be assured sufficient latitude and opportunity to provide an incentive for improved efficiency and to take advantage of all significant advances in medical and nursing care and technology.

In connection with autonomy, here is our recommendation:

It is recommended there be acceptance of the principle that once a hospital budget has been approved, the hospital would be free to operate for that year within the overall budget figure without being required to adhere to the specific budget allotment for individual services and departments.

Now, in explanation of that, I would like to say that probably we do not all subscribe to it just in as bald a form as that. We do not just ask for a blank cheque, once we get the final total.

We realize that we are subject to rules







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TORONTO, ONTARIO

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and regulations by other people, but we do ask that  
there be some administrative elbow-room; something to  
take care of the day-by-day difficulties that come up.  
The changes that nobody can foresee 15 months ahead  
and that is what we mean in that one.



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Now, going on to hospital operating costs, to a significant extent, hospital operating costs reflect the same factors as those experienced by other enterprises in an expanding economy --- a steady upward spiral in the cost of goods and services. Factors of continuous operation and the rapid advances in patterns of patient care continue to contribute to rising costs.

Our recommendation in that regard is to provide financial latitude to meet these needs and as a further measure of economy for hospitals it is recommended that hospitals be permitted to retain probably a larger share of income from semi-private accommodation which would help us in our planning, it would help us in our elbow room and it would help us to a great degree.

COMMISSIONER McCUTCHEON: You only mention semi-private, I assume you mean the differential in private and semi-private?

MR. WALLACE: Both, yes.

And, with regard to capital costs we recommend the principle that a substantial portion of the capital cost of a hospital continue to be provided by the community, by the Metropolitan Board or by the Township, two-thirds to be shared and we suggest evenly between the Province and the Federal Government and that the decision should be still with our Commission as to what was required and that once they had given their decision, then we, on our part, would pick up the obligation of providing one-third and we would ask that the other two-thirds be provided by Government sources, Provincial and Federal.

I think it is important that we should







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get this to you, that we feel the one-third, one-third, one-third is a fair and reasonable division in our opinion. That question was asked this morning and I do not think it was very clearly and precisely answered. Perhaps there are very good reasons why it could not be clearly answered, but it is our opinion that that would be a fair and reasonable division.

With regard to staffing, understanding and cooperative endeavour among all agencies concerned in meeting staff needs is of continuing importance. As the basic physical facility for many training programs and as the employing agency for the majority of graduates, hospitals feel both an interest and responsibility to make their contribution to any planning which may affect the availability and performance of paramedical personnel.

The need for expansion of educational facilities to provide for increased numbers of certain technical and professional personnel warrants careful attention. We have had financial support and asked for financial support for educational assistance and it should constitute a major consideration when we figure our budget in the Fall and present them to the Commission.

Improvement in the performance of staff is aided by institutes and other similar educational activities.

In this connection I would plead that we have permission in our budget to have numbers of hospital employees come to central points where they can have their educational facilities, where they can have their education improved, where they can be helped so they





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can go back to their own hospitals and be of more value to it.

Then, with nursing education, as a reflection of its basic philosophy, the Board of Directors of the Ontario Hospital Association endorses the statement of the Canadian Hospital Association regarding hospital schools of nursing. We believe strongly that the future holds a definite place for the hospital school as enunciated in the first of the eleven principles contained in this policy statement.

The variety of programs being conducted concurrently does, we believe, provide a basis for an ongoing process of development out of which will evolve a definite pattern which will be acceptable on its proven merits.

We expect to be questioned on this matter. This is a different concept and a different philosophy than has been put forward yesterday and that has come before you. We are very definite in this recommendation, we are very definite in this matter, and we will expect that you will question us on it.

There is another problem under number 6, medical services in long-term illness hospitals. A problem has arisen in those hospitals in the Province of Ontario since the Hospital Insurance and Diagnostic Services Act does not permit the inclusion in the hospital budget of monies that are to be used for the reimbursement of practitioners for medical services to patients, some means is needed to insure that patients in the chronic and convalescent hospitals of the Province have made







Wallace 9494

available to them the medical care their condition requires and to which they as citizens are entitled.

Our recommendation there is in the nature of a stop-gap recommendation. As an interim measure, it is recommended that special provision be made to provide for medical services to such patients through the mechanism of the per diem rate under the Hospital Insurance Plan of the Province.

This was a problem for some time, but it has been intensified in some respects and brought to a head by the limit of the financing imposed by the Hospital Insurance Plan. What we are proposing is certainly a stop-gap means to afford positive, immediate relief to these hospitals with the understanding we continue to work towards the day when a more permanent solution can be found to insure the best possible medical services in these institutions.

The next item is the utilization of facilities. A definite cooperative planning function should be maintained among health and welfare agencies to insure that the relationship of hospital and domiciliary facilities is clearly established in order that each facility is adequate and properly utilized.

We have stressed in our brief various factors that affect the utilization of hospital facilities. This is a shared responsibility of both the administration and the medical staff at the local level. We have also included the cooperative work being undertaken by this Association, the Ontario Medical Association plus the Association of Medical Record Librarians towards a program





Wallace 9495

to assist in this local endeavour. We do point out as a conclusion that while there is a degree of planning on a centralized basis as to physical facilities, the relationship of patient care accommodation and domiciliary services warrants attention and does justify a definite coordinated function among the agencies involved. We make mention because of the special problem for teaching hospitals being members of the Ontario Hospital Association.

Because of the changed status of a public patient under a hospital insurance plan, consideration needs to be given to the continued provision of adequate clinical material in teaching hospitals for medical students and internes.

Public education, preferably on a coordinated basis in terms of the interested agencies and organizations, is considered necessary to gain the cooperation and understanding of the community in this problem.

The Ontario Hospital Association affirms its belief in the soundness of an independent commission form of operation for the administering of the Public Hospitals Act and the Hospital Insurance Plan of this Province.

THE CHAIRMAN: Thank you, Mr. Wallace. Mr. Wallace, Sister Janet and those with you, I take it that you were present during the previous hearing from the fact of what we saw and are there any statements or observations that any one of your delegation now would like to make arising out of what you heard in the previous discussion?

MR. WALLACE: This morning's discussion?







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THE CHAIRMAN: Yes.

MR. WALLACE: Mrs. Aylen, have you any comments?

MRS. AYLEN: Mr. Chairman, I naturally am very interested in the subject of nursing education, and I am afraid I disagree with a good deal of the publicity that has been given to the drudgery of the nursing student. I, as a member of the Association, would like to appeal that a great deal of consideration would be given to keeping the same type of schools as we now have with perhaps the ultimate aim of reducing the length of time spent in the clinical or the didactic part of the program. I would like to mention the fact of the nursing assistants; I think one of the members asked if there was an adequate supply, and I do not think there ever would be an adequate supply. The program for the nursing assistants, I feel, should be popularized and made as attractive as possible and if possible, it should be continued in close association with a hospital. I could give you an example of a school in Ottawa that was situated in a building far removed and at which they could not get more than six or seven applicants in a session. We opened a school at the Ottawa Civic Hospital and we now have a class of 36 and 45 and no trouble in getting the girls to come and to graduate them with honours.

THE CHAIRMAN: Thank you, Mrs. Aylen.

MR. WALLACE: Have you any comments, Mr. Dick?

MR. DICK: Mr. Chairman and members of the Commission, I am particularly interested in the





Dick 9497

autonomy of the local hospital. It is very difficult to reconcile these things always with partiality when money is coming to them and retain local interest by people who will provide time for management when their decisions are overruled by regulation or dictation by a commission. We are concerned in our area with this particular phase of the operation and would stress again the importance of leaving something for the local people to do in the way of decisions.

We subscribe wholeheartedly to the principle mentioned here of, outside of general control which is necessary, that once a budget is struck that the local board be given a reasonable amount of latitude in making such adjustments as are necessary once it was started and not be called upon to account for minor changes or something of that nature which has been the case up to this time and which has been one of the problems of the institutional hospital plan as it has been developed.

MR. WALLACE: Sister Janet?

SISTER JANET: I would like to just make a comment about the discussion about pharmacists in the hospital entering the role of filling prescriptions for all people who came to the hospital. I would like to point out that hospitals are not really a commercial enterprise even though we talk about them as though they may be. When we are providing drugs to the medically indigent patients in the out-patient clinic, even if they may pay a nominal amount or even if they pay the full cost of the drug, there is never any thought of a mark-up







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Rev. Sister Janet

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such as would be necessary in a commercial drugstore.  
To me it would be entirely out of our field to be dis-  
pensing drugs to everyone who needed drugs.





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THE CHAIRMAN: Thank you for those observations.

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Now, it might be in order for me to remark at this time that hospitalization, even nursing education, the sale of drugs, are necessarily provincial under our constitution, Canadian Constitution; these are provincial matters. So it is not all phases of hospital administration that come within the ambit of this enquiry. There are many details of the operation of hospitals which are purely local and provincial and which do not fall in any way into the ambit of authority of the federal government.

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That doesn't mean, of course, that the enquiry is not concerned with the operation of hospitals, because the financial operation of hospitals, to which the Federal Government contributes, is naturally a very important aspect of it; and nursing education naturally comes in because costs of nursing education today are part of hospital budgets, operating budgets, which are shared by the Federal Government as well, and shared more or less on a 50-50 basis. So there may be some aspects, some references in your brief, perhaps, to which no further mention may be made because they may fall into two categories, either as being details which are of necessity excluded from the ambit of the enquiry and, secondly, and more importantly, if you will accept this, in those phases where you have spelled out your position clearly, and we read it without being in any doubt what your position is, then again we do not need to pursue the questioning to clarify a position that







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4 is already clear. Our questioning is intended to resolve  
5 any ambiguities or to clarify positions taken which  
6 do not appear to us to be as clear as you intend them  
7 to be.

8 Now, on this question, I am going to  
9 deal with this question of the special problem of  
10 teaching hospitals. It is now a little over two years  
11 since the hospitalization program has been in operation  
12 in Ontario. Can you say, those from the teaching  
13 hospitals, that there has been any change in the public  
14 attitude, in the attitude of patients in terms of the  
15 clincial material for the teaching hospitals?

16 MR. WALLACE: From my own standpoint,  
17 coming from a teaching hospital? I would have to say  
18 no, none whatsoever. The co-operation which is extended  
19 to teachers depends wholly and entirely in my opinion  
20 on the approach and attitude of the medical man, and  
21 he can get full co-operation from the president of  
22 General Motors, he can get full co-operation from many  
23 of his private patients, depending on the manner of  
24 his approach. We respect the right of the patient who  
25 does not want to be taught on.

26 THE CHAIRMAN: How do you differentiate  
27 them?

28 MR. WALLACE: By their general attitude  
29 beside the physician at the time he says: "I propose  
30 to do so and so," and we respect his wishes from that  
point on. We don't ask for a category, classify them  
when they come in, but depending on the physician  
sitting beside the patient the following morning and you





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4 either get a yes or no.

5 THE CHAIRMAN: What is the position  
6 in Ottawa Civic, Mrs. Aylen?

7 MRS. AYLEN: We haven't encountered  
8 any difficulty, but agreeing with Mr. Wallace, the  
9 attitude of the patient has a lot to do with it, and  
10 the personality of the head of the department. From a  
11 public relations point of view, I have never heard of  
12 any cases.

13 THE CHAIRMAN: This topic you raise  
14 in number 8 has been suggested to us in several provinces,  
15 and with some emphasis in at least two provinces. What  
16 about St. Michael's, Sister Janet?

17 REV. SISTER JANET: Well, Mr. Chairman,  
18 we haven't had any problems to a great extent on the  
19 part of the patients refusing to be used as clinical  
20 material, but there is an inherent problem in it because  
21 the patient has the right to say either he can pay for  
22 his own doctor or he has medical insurance and therefore  
23 he wants to be operated on by the doctor of his choice,  
24 and if the doctors don't play cricket, let's say, at  
25 this point and say: "I am sorry, this is a teaching  
26 area where you are. I will supervise your operation but  
27 I will be helped by the resident," and so forth, there  
28 is a danger to the teaching program and it is something  
29 we are all trying to fight against.

30 THE CHAIRMAN: Do you visualize a  
situation could be brought about that patients who might  
go to a teaching hospital, that to do so on the basis  
that that was the natural order of things in that hospital





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and would have to submit.

MR. WALLACE: We understand that that is no problem whatsoever in the Saskatoon University Hospital and we understand it is of no consequence, it just is natural and normal.

COMMISSIONER McCUTCHEON: Because people understand it in advance?

MR. WALLACE: Yes.

MR. MARTIN: I think the subtle change is involved in the question where the large teaching hospitals have traditionally closed wards, and there is this problem that Sister Janet mentioned. This could be amplified, if you let your imagination run away, where a person has a certificate and he says: "I have paid my way. I want to have certain privileges." When you carry this over to where a pre-paid plan is on a fairly comprehensive basis, then the problem as we see it is public education. The point is that even if we have a medical and hospital plan that is fully pre-paid, the rights of the teaching hospital may have difficulty in maintaining that which is a regulation of the hospital. Public opinion is a great thing, and if it came to the point where they said we are not going to take these people on staff situations, then you could have a very serious impairment in the way of teaching material. It is a matter of public education; that is the point that is stressed in the brief.

THE CHAIRMAN: Now, perhaps following from there and implicit in something you said, Mr. Martin, this matter of the closed wards, we have had representations



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4 made to us, and I expect we may have more, that hospital  
5 wards should be available to all practitioners and this  
6 idea of the closed ward is something that is detrimental  
7 to the practice of medicine. I am just paraphrasing it.

8 Mr. Wallace, have you any observations  
9 to make on that, because you are the operators of these  
10 hospitals that are either closed or open or whatever  
11 they may be?

12 MR. WALLACE: I have an observation to  
13 make, that in my opinion it is not a detriment to the  
14 practice of medicine. I say that patients who receive  
15 care in closed wards, we almost feel a much greater  
16 responsibility for their wellbeing than we feel for the  
17 responsibility of the fellow who, of his own free will,  
18 chooses his own doctor and chooses to go that way.  
19 We feel a personal responsibility for the wellbeing and  
20 our doctors are very, very jealous of the medical audit  
21 results coming out of the closed areas so that they  
22 cannot be criticized for having provided sloppy care  
23 to the public, they are very jealous of the results  
24 coming from the closed wards, and I think the patients  
25 benefit and the medical students in their teaching and  
26 learning process benefits, and I think the country  
27 benefits by a tightly knit, well-organized university  
28 arrangement with hospitals which have a sufficient  
29 number of patients for teaching wards.  
30

31 COMMISSIONER BALTZAN: That doesn't  
32 belong only to closed hospitals; that will apply equally  
33 to a well-organized, departmentalized hospital with  
34 strict supervision over their departments.







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4 MR. WALLACE: That will apply that  
5 way. But the doctors who have responsibility for the  
6 closed wards are very jealous that everything will be  
7 of a calibre as it is possible to make.

8 COMMISSIONER BALTZAN: There is the  
9 same jealousy in both wards?

10 THE CHAIRMAN: Perhaps we should make  
11 differentiation between the teaching hospitals. It is  
12 acknowledged that closed wards are a necessity in the  
13 teaching area. Accepting that as not a dictum but as a  
14 basis for discussion, once we leave the area of the  
15 teaching hospital and having hospitals closed to some  
16 doctors and open to others, doctors have said that that  
17 is bad for the practice of medicine. But some doctors  
18 just can't get into a hospital and they can't practise  
19 in that sense, and others have said it has given rise  
20 to the bringing into being of small private hospitals  
21 over which there is no proper control or degree of  
22 inspection or anything of the kind.

23 MR. WALLACE: That could happen and  
24 it might happen. But I don't think with good overall  
25 judgment that that happens -- certainly not in the  
26 majority of cases, certainly in the very minority of  
27 cases, and you can hardly legislate and arrange for and  
28 protect every situation, and I feel that if a young man  
29 who may go into a small community and not get his  
30 scholarship that it might be expected that he should  
get, I feel sorry for him.





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THE CHAIRMAN: Should the hospitals permit the medical profession or anyone else to close the doors of the institution to anyone qualified, of course, to practise?

MR. WALLACE: No, not if he is qualified to practise.

MR. DICK: Mr. Chairman, if I may speak for a small hospital, it is our experience that the medical profession govern themselves to a very great degree as to who comes on the staff. In the smaller communities I doubt very much, at least, it is not in our community, that anyone has been excluded from the staff who has qualifications. The work that they do is regulated by their colleagues and they determine what they are qualified to do and recommend to the Hospital Board the work they may do in the hospital and the hospital administrative staff, in turn, undertake to help them to do the things they can do and progressively go on to do other things.

COMMISSIONER FIRESTONE: Mr. Wallace, I would like to echo the Chairman's remarks that this is such a well-written and well-substantiated brief it answers most of the questions one might want to ask. I would like to refer only to paragraph 96 on page 32, and then going on to page 33, in which you speak of the laboratory survey presently in progress in Ontario and one of the sponsoring agents is the Ontario Hospital Association.

Do you expect that the report based on that survey might be available in the course of the next







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several months?

MR. WALLACE: That survey has been carried out by Mr. Gibbard. I am sorry I can't tell you how far along he is right now. He has been to us twice. Do you know, Mr. Martin?

MR. MARTIN: It is anticipated the report of the Committee should be available by Fall of this year, of 1962.

COMMISSIONER FIRESTONE: Would it be possible to have a copy of that survey made available to the Commission by sending it to our Secretary?

MR. MARTIN: Certainly, I would be quite happy to pass on the interest of your group on the results of this to the Committee that are working on it. As one of the constituent parties I would imagine that the results of the study would be available to a group such as yours. I would have to check with the Committee; I would think so.

COMMISSIONER FIRESTONE: If you were to check we would appreciate it very much if it could be made available if that is suitable to the sponsoring agencies.

On the same subject in a somewhat different field, in paragraph 97 on page 33, you refer to your Association having undertaken some interim investigation with respect to group purchasing of drugs and the use of formularies. Are some memoranda or studies available on these two subjects, sir?

MR. WALLACE: The studies are actually in process right now. Mr. Martin has Committees studying





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several places in the United States and one or two places in Canada. He would know how far they are along the road now.

MR. MARTIN: Sir, we are in the investigative stages at the moment on a fairly extensive basis and the Committee is still continuing and probably will not be reporting until late summer or early Fall.

COMMISSIONER FIRESTONE: 1962?

MR. MARTIN: Yes.

COMMISSIONER FIRESTONE: Again, sir, would it be possible once these reports are available to make copies available to this Commission by sending them to our Secretary? After an examination of these reports our Research Director may wish to get in touch and get a little elaboration and explanation.

MR. WALLACE: That would be acceptable to our Association.

COMMISSIONER FIRESTONE: Thank you very much. It is most helpful.

COMMISSIONER McCUTCHEON: Mr. Wallace, we were told this morning and I think you were here when the brief of the Canadian Hospital Association was presented that it had been sent forward in draft form to its constituent members and that no serious dissent had been taken by any of the constituent members.

I would just like to ask about two recommendations the Canadian Hospital Association made which are absent, not dealt with in your brief, to see what the position is. Recommendation 2 was that the Hospital Insurance and Diagnostic Services Act be amended







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3 to include the care of the mentally ill with special  
4 emphasis on adequate emergency services at point of need.  
5 What is the position of the Ontario Hospital Association  
6 on that?

7 MR. WALLACE: I would turn to our  
8 Executive Secretary, who is also quite familiar with the  
9 Canadian Hospital situation inasmuch as he is past-  
10 President.

11 MR. MARTIN: Mr. Chairman, I think  
12 specifically while the Ontario Association has not a  
13 policy pronouncement on this point it is an accepted  
14 fact that there has been a desire to integrate the  
15 medical illness within the stream, the more common  
16 stream of the surgical illness features and in this  
17 sense, while not having been specifically dealt with, the  
18 recommendation was included in the Review Committee of  
19 our group and so, in a sense, therefore, this Association  
20 is supporting the Canadian Hospital Association in that  
21 recommendation.

22 COMMISSIONER McCUTCHEON: I go to  
23 Recommendation 3: "that the Hospital Insurance and Diagno-  
24 stic Services Act be amended to include the provision  
25 of out-patient services, as defined in the Act, as a  
26 required condition in every Dominion-Provincial agreement."

27 What is the position of the Ontario  
28 Association on that, Mr. Wallace?

29 MR. WALLACE: As a requirement?

30 COMMISSIONER McCUTCHEON: As a required  
condition, in other words, the recommendation is that the  
Federal Government shall give no money unless you provide





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out-patient services.

MR. WALLACE: No, sir, I think that is a little precipitous. I think it is jumping the gun. I think it is early. I don't think it should be a recommendation.

COMMISSIONER McCUTCHEON: In other words, your position is that you are not supporting that particular recommendation?

MR. WALLACE: Not wholly and entirely in that form.

COMMISSIONER McCUTCHEON: In what form, then?

MR. WALLACE: Well, I think that there must be some further study in the Province of Ontario before we step in with both feet to out-patient coverage.

COMMISSIONER McCUTCHEON: In other words, would it be fair to put it this way: you are not supporting this recommendation as something that should be done immediately?

MR. WALLACE: Correct.

COMMISSIONER McCUTCHEON: Thank you.

MR. WALLACE: It requires some further study, at least, in the Province of Ontario.

MR. MARTIN: I might say that the Association at its annual meeting of two years ago did record a resolution that requested us to approach the Commission in Ontario to have the benefits, to have the out-patients benefits, covered as part of the main plan. Mr. Wallace will remember that. We have carried on this discussion with the Commission, and I would sense that







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in their wisdom and as part of this problem, there have been extensions recently, as recently as April 1st in Ontario.

COMMISSIONER McCUTCHEON: Pretty limited.

MR. MARTIN: There was an extension beyond emergency care. There was an extension into follow-up emergency care and also some surgical procedures, treatment procedures and so on.

MR. WALLACE: Step by step.

MR. MARTIN: Step by step.

COMMISSIONER McCUTCHEON: This would be a fair statement to make, you are not supporting the recommendation that the Federal Government make this a requirement. You want to deal with it provincially.

MR. WALLACE: Provincially.

COMMISSIONER McCUTCHEON: Thank you.

COMMISSIONER STRACHAN: Are these expansions specifically designated?

THE CHAIRMAN: The ones that came in the 1st of April, yes.

MR. WALLACE: Yes.

COMMISSIONER STRACHAN: For example, do they include the E.S.G.?

THE CHAIRMAN: They vary, accidents and so forth.

MR. WALLACE: Yes, formerly an accident within 24 hours was covered automatically, paid for automatically. Now, the follow-up care of that accident is paid for, and also certain procedures which a doctor





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might formerly have felt it desirable for a patient to come to the hospital to have the procedure carried out, now that is paid for if the doctor feels that, in his judgment, it could be carried out on an out-patient basis.

COMMISSIONER STRACHAN: You are speaking of diagnostic procedure?

MR. WALLACE: And some treatment.

THE CHAIRMAN: This question of the out-patient service, you are not ready for it in a complete way yet?

MR. WALLACE: Not in a complete way. I think it requires a little more study, co-operative study.

THE CHAIRMAN: Do you see the extension of the out-patient service as something that will help reduce bed utilization?

MR. WALLACE: Well, I just wonder what is meant by the phrase "reduce bed utilization".

THE CHAIRMAN: Well, it means this: a person who might be hospitalized for a diagnostic purpose, that same person could have the diagnosis made in an out-patient department and he doesn't occupy a bed.

MR. WALLACE: That is correct. It is going to be very difficult to demonstrate that statistically because of the big waiting list in hospitals. If it was demonstrable statistically then you would show a drop in your usage of beds, but there is still such a very high backlog.

THE CHAIRMAN: Let me put it more bluntly do you sense that people are sent to hospitals and







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occupying beds while diagnosing process is being done which could be done outside, but because the diagnosing service, the x-ray and so forth are free in the hospital and has to be paid for outside, that there is a tendency to put people in the hospital merely because of it?

MR. WALLACE: That is a pressure doctors are subject to, I hear, and I believe that, on occasions, may happen. However, doctors, from my experience, have a very high waiting list of critical and important jobs to be done for their patients and they don't sabotage their more critical and more necessary jobs unless they have, shall we say, succumbed to the pressure of the patient. It is very small compared to our 25,000 admissions a year; the number of admissions that would fall in that category to me are very small, in my experience.

THE CHAIRMAN: You are speaking for your own hospital?

MR. WALLACE: Yes.

THE CHAIRMAN: Is there anyone here who could speak for the hospitals across the board?

MR. WALLACE: Maybe Mr. Dillon might. Are there hospitals that are pressured?

THE CHAIRMAN: Have you heard that? Is that something that the gossip or so forth, the way things permeate through an organization and finally get attention?

MR. DILLON: There have been rumours, that is all, nothing specific in my experience.

COMMISSIONER VAN WART: Does the Hospital





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Commission in Ontario refuse payment for patients who come in simply for diagnostic purposes?

MR. WALLACE: I believe so. I believe they have a mechanism which says to the hospital, sorry, no payment.

COMMISSIONER VAN WART: Has that been enforced many times, at many of the hospitals in Ontario?

MR. WALLACE: I have seen it two or three or four times in 75,000 admissions. I am sorry I can't answer beyond that.

THE CHAIRMAN: How may the hospital control that situation?

MR. WALLACE: Well, it is done at our hospital by sort of a colleagueship.

THE CHAIRMAN: Admissions are under the control of the doctor?

MR. WALLACE: That is right.

THE CHAIRMAN: The discharge is under the control of the doctor?

MR. WALLACE: Yes, sir.

THE CHAIRMAN: And the hospital gets penalized?

MR. WALLACE: Yes, sir.

THE CHAIRMAN: Are you satisfied with that?

MR. WALLACE: Oh, we would, in a friendly manner, take that up with our doctor in question. If some fellow did that two or three or four or five times the friendliness would disappear. We would say to him in a friendly fashion this is what is happening and we







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would get co-operation.

COMMISSIONER VAN WART: Medical disciplinary boards in your hospitals review situations like that?

MR. WALLACE: That is right, the Admission and Discharge Committee review every case.

MR. MARTIN: I think it is very difficult to speak of the Commission, but I think they are working this on a per claim basis and there is a great amount of correspondence back and forth between the medical referees of the Commission and the medical persons on the staff level. I think it is symptomatic that this occurs amongst the public, and with the doctors, to a degree, the thought that outside a bed you will pay and somebody pays if you get into a bed.

You won't get it if you walk in and out again. I think, Mr. Chairman, the resolution I mentioned that the Assembly recorded two years ago, I think it is a source of difficulty between medical staff and hospital administration, hospital administration in the plan and medical staff in the plan, to endorse the plan and this puts a very great strain on everyone's individual honesty and straightforwardness because obviously these things vary from point to point.





Wallace 9515

COMMISSIONER BALTZAN: Your complaints really come mostly from people, rather than on behalf of, like members of the staff. Patients complain of not having this opportunity of obtaining these diagnostic tests outside the hospital, and they can get it when they are in the hospital.

MR. WALLACE: I would say yes to that question, because people come to me and discuss that very facet of it. They come to me and say why, and I just have to explain that, quite frankly, as to the whys of it.

COMMISSIONER BALTZAN: And you find that they then understand you?

MR. WALLACE: They understand it, but they do not willingly accept it.

COMMISSIONER BALTZAN: Still resent it?

MR. WALLACE: They resent it a bit. They resent it to a degree.

COMMISSIONER BALTZAN: I have no further questions, but I must tell you this: The questions that are put earlier, before noon, have been fully answered by you in your summary and conclusions and recommendations in your brief.

COMMISSIONER STRACHAN: Mr. Martin, without repeating the question regarding the dental clinics which I put to the Canadian Association, would you care to amplify your answer in respect to Ontario?

MR. MARTIN: Obviously your question was particularly related to children, as I understood this morning, the problems that come up.







Martin 9516

COMMISSIONER STRACHAN: With some special reference ---

MR. MARTIN: To their other adult stages. This already has been receiving particular attention, of course in, for instance, children's hospital in Toronto has a very active and extensive dental department that takes care of this and there has been an extension of this into several of our hospitals in this area in Toronto so that there is, as I say, in this Province special attention being given to this problem at the present time.

COMMISSIONER STRACHAN: Do you see any development in other areas in the Province in the larger centres?

MR. MARTIN: Yes, I think that this is a fairly quickly developing phase at the moment in this Province.

COMMISSIONER STRACHAN: Thank you very much.

THE CHAIRMAN: Now, Mr. Wallace, I was intrigued with the recommendation on Page 15, at least the reference on Page 15, Paragraph 45 where the proposition is put forward that sweepstakes, legalizing sweepstakes is, of course, in the jurisdiction of Federal Parliament. Your suggestion is very relevant in that context.

MR. WALLACE: We have studied the dollar economy of the thing, and it's a snare and a delusion. You couldn't possibly with sweepstakes make up even a small percentage of what the Province and the





Wallace 9517

Federal people are doing for us. You couldn't even come close to it. It's just a joke.

I am sorry I do not have the dollar figures with me, but I have seen the results of these studies of what would be possible, and it wouldn't even buy us peanuts.

COMMISSIONER McCUTCHEON: Might pay for the extended out-patient facilities.

MR. WALLACE: We will take it under advisement.

MRS. AYLEN: Mr. Chairman, could I say a word on this? If anything could be done in a local way to enable the small hospitals to run some sort of gambling device, shall we say, they might get some equipment, and everybody would have a good time, but not quite on the basis of a national one, such as this.

It is becoming more and more difficult for people to raise money, and certainly this is one way, in a small local way, where I think personally --- I am not speaking for the Association --- would help out a great deal.=

THE CHAIRMAN: Well, I don't know whether if I misunderstood you, Mr. Wallace. Do you say you are repudiating what is on Page 15, because what you say there is: "We wish to make a comment on a proposal to legalize sweepstakes in Canada..." Now the proposal has been made to us before by the Association de Medicine de Langue Francais de Quebec. The same proposal came in in a brief of the Senior Citizens' group in Western Canada.







Wallace 9518

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4 Anyway, you go on to say "We wish to  
5 make a comment on a proposal to legalize sweepstakes in  
6 Canada for the support of hospitals. Insofar as Ontario  
7 is concerned, such a proposal originated with one of the  
8 municipal councils and was subsequently the subject of a  
9 questionnaire sent by that council to 900 other municipi-  
10 pal councils in the Province. It has been reported that  
11 of these 300 questionnaires returned, 260 or 83% endorsed  
12 the proposal. While the percentage returned may be less  
13 than one-third, there is still a significant number of  
14 municipalities who feel this approach to hospital capital  
15 financing is wanted. In our view, this reflects the  
16 very situation outlined in the preceding paragraph wherein  
17 municipalities are becoming increasingly hard-pressed for  
18 revenues for such purposes."

19 So you don't express an opinion.

20 MR. WALLACE: No, we do not express  
21 an opinion.

22 THE CHAIRMAN: This is indicative of  
23 the difficulties of getting capital money.

24 MR. WALLACE: Except that it does show  
25 that 300 municipalities spoke up and what they were really  
26 saying is yes, gee, it's hard to raise the money. Let's  
27 try something else. I think that's about what it means;  
28 that they felt the pressure and difficulty of raising  
29 money, and they would look at even this means.

30 THE CHAIRMAN: Now then, you have told  
us this morning that what you favour is the municipal,  
the local organization putting up one-third of the capital  
cost.





Wallace 9519

MR. WALLACE: Well, not the local organization, as such, putting up one-third, but the local people.

THE CHAIRMAN: The community.

MR. WALLACE: The community, plus, that is, the tax-raising body having some basis whereby it would contribute, and the tax-raising body I think should still accept the responsibility and it's our feeling that one-third, one-third and one-third is about a fair division when you are asked to state it specifically.

THE CHAIRMAN: I am only mentioning that in the light of the response that the municipalities say they cannot find the capital money.

MR. MARTIN: But in Ontario, at the present time, sir, there is about 60% they are having to raise.

THE CHAIRMAN: What is the situation in Metropolitan Toronto?

MR. WALLACE: The situation in Metropolitan Toronto is, in my case, no.

THE CHAIRMAN: What is it? Do they pay or do they not?

MR. WALLACE: They do not, Metropolitan Toronto, at the present time.

THE CHAIRMAN: I am not asking for an opinion on whether that is right.

MR. WALLACE: They do not support capital grants.

THE CHAIRMAN: Is that a policy of long standing?







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MR. WALLACE: It has stood since some time in the end of 1956 or '57.

THE CHAIRMAN: Is it related to the entrance of the Government into the hospitalization financing picture?

MR. WALLACE: It would probably have had an effect to bring that about.

COMMISSIONER McCUTCHEON: It anti-dated that, did it not?

MR. WALLACE: Well, Metropolitan Toronto made a grant in 1956, of which I am well aware.

COMMISSIONER McCUTCHEON: I think that was the last one?

MR. WALLACE: That was the last one.

COMMISSIONER McCUTCHEON: Hospital insurance came in May, 1959.

MR. DICK: In the field of business this same philosophy is spilling over to the effect that Government has now picked up the tabs on operating the hospital; should also pick up the tab on building them, so that the resistance to popular appeal for hospitals, especially in the smaller areas, is considerably greater than what it was.

THE CHAIRMAN: At the risk of keeping you here a few more minutes, this deals with your autonomy proposition in number 1 of your conclusions and recommendations. Is this the situation: The hospital will have a budget, and you are recommending that once that budget was submitted that it should be accepted so that the





Wallace 9521

hospital can go forward with its year's program. Is that the viewpoint you are putting forward?

MR. WALLACE: Well, to a degree. I do not go along with the philosophy of giving us a blank cheque. I do not go along with it.

This recommendation, as it is worded --- I might amplify --- getting a blank cheque and then go ahead and spend it as we see fit. I do not go along with that wholly and entirely, but what we are really trying to say is that we would like a little more authority given to the local hospital if it finds itself in the particular and peculiar situation, if it lives within its budget, that it might in its jurisdictional judgment, that it might in its judgment do something a little different from what was decided fourteen or fifteen months ago.

THE CHAIRMAN: You prepare a budget it is submitted and it is approved.

MR. WALLACE: Yes, and it's pretty well detailed. It's a pretty detailed budget.

COMMISSIONER McCUTCHEON: You want the right to transfer from one account to another.

MR. WALLACE: We would like some breathing space and elbow room within that. If the hospital is able to live within what the Commission said they should live within, we would like that hospital, if conditions and situations arise over which they had no knowledge fourteen months ago, that it be granted that.

THE CHAIRMAN: That is the very thing. What about if, because of conditions, deficits exist at







Wallace 9522

the end of the budget period? What is the situation now?

MR. WALLACE: Well, I would only --- I can speak for a number of hospitals I know of, but for our hospital, the Commission looks at the deficit in an intelligent and understanding manner, and if it is justified, we get the money without question. That's just about it, and I understand that happens in other hospitals.

I have other colleague hospital superintendents who say, "We ran over this year because of thus and so, and because of so and so and we took it up with the Commission." The Commission has, in all the ones I have heard about, been understanding and generous. True, they do not shovel the money out, but they are understanding and give intelligent understanding to the situation like that.

THE CHAIRMAN: And part of the operating cost is shared by the Federal Government?

MR. WALLACE: Correct.

THE CHAIRMAN: We wouldn't want to suggest they get too open-handed even with Federal money. The situation, as you find it, insofar as this device for sharing is working out reasonably satisfactorily in that regard?

MR. WALLACE: As I understand it, yes, and from my personal experience, admirably.

THE CHAIRMAN: Is that the opinion of the rest of your colleagues here this morning?

MR. DICK: I feel the same way about it.





Dick 9523

It's just little minor things that are irritating, more than the major overall.

THE CHAIRMAN: I am talking about the overall principle of it.

MR. DICK: The overall principle is very satisfactory.

THE CHAIRMAN: And the way it has to be worked out?

MR. DICK: If it were headed in the direction that it started out, then in a very few years we wouldn't need a hospital administrator. All we would need is someone who would sit down and tell the doctors what to do in that sphere of activity, and the financial part of it would be done from Toronto.

I think that is a bad idea. We should have trustees of the hospital aware of what is going on. In order to be aware, they must have decisions to make.

COMMISSIONER VAN WART: Does your hospital Commission look upon monies you raise from your, say, Tuck Shops or private donations to your hospital, and so on, etcetera, as items you can administer yourself, or do you have to put that in your budget against your per diem?

MR. WALLACE: They have always respected that and honoured that as being sacred to the hospital. If we interest people in doing things to give us money, to do this and this, they have always respected it and honoured it. It belongs to us to buy two incubators instead of one.

COMMISSIONER VAN WART: Have you been







Wallace 9524

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3 systematically developing the Tuck Shop idea in your  
4 hospital?

5 MR. WALLACE: That, in many hospitals,  
6 is the baby of the women's auxiliary.. They have worked  
7 it to good advantage and they give a service to both  
8 patients and the hospital, and visitors, and I think  
9 that the women's auxiliaries in our Province are doing an  
10 admirable job in little side issues like that.

11 THE CHAIRMAN: Thank you very much,  
12 Mr. Wallace, Sister Janet, Mr. Martin, and your colleagues.  
13 These recommendations and studies you have made and with  
14 the information and help that you are going to give us  
15 as the other things become available, will be very much  
appreciated.

16 MR. WALLACE: Thank you for your kind  
17 attention and we are very grateful indeed to appear before  
18 you today.

19 THE CHAIRMAN: We will now adjourn  
20 until two o'clock.

21 ---Luncheon adjournment.  
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---On resuming at 2:00 p.m.

THE SECRETARY: Mr. Chairman, I will call forward the brief of the Medical Liberty League and their submission will be exhibit 257.

---EXHIBIT NO. 257: Submission of Medical Liberty League.

SUBMISSION OF  
MEDICAL LIBERTY LEAGUE

APPEARANCE: Dr. A. B. Davies

THE CHAIRMAN: Yes, Dr. Davies.

DR. DAVIES: Mr. Chairman, I thank you for this opportunity to come and appear before you. I am sure the submissions I will make will be of great interest in the culmination of the objectives of your esteemed Commission.

1. The report of a former Royal Commission, appointed by the late MacKenzie King's Government, under the chairmanship of Mr. H. H. Hannam, president of the Canadian Agricultural Federation, embodied in a booklet, entitled "Health On The March", also his oral report, presented to the Special Parliamentary Committee on Social Security on date of June 10, 1943, indicated that the health services in Canada were far from being satisfactory. Evidently the same motivation prompted our Prime Minister, the Rt. Hon. Mr. Diefenbaker, since







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3 the same conditions continue to prevail, perhaps in  
4 serious need of of rectification. Mr. Hannam's  
5 Commission were instructed to report on the health  
6 conditions in Canada as well as to make recommendations  
7 for improving them. I heard his verbal report to the  
8 Special Committee on June 10th, 1943, as I was the last  
9 speaker, appearing before the Parliamentary Committee.

10 I have also read his written report, which may be  
11 summarized in a few words; e.g. Health conditions are  
12 lamentable, and the only solution in sight is total  
13 socialization of all health services and practices.

14 2. The Federal authorities refused to  
15 accept the recommendations of Mr. Hannam's Commission  
16 and proposed an alternative measure which was rejected  
17 by the Special Committee and the proposed Act was thus  
18 shelved, where it still remains to the best of my  
19 knowledge. I might say that to the best of my knowledge  
20 also it was not permitted to go to the floor of  
21 Parliament.

22 3. Allow me here to offer a short  
23 explanation for the terms State and Socialized Medicine,  
24 which often have been used indiscriminately, yet, there  
25 is an enormous difference between them. By the medical  
26 status quo, all practitioners of medicine (orthodox  
27 or not) have to depend on sickness for their means of  
28 livelihood. A healthy nation, will automatically "starve"  
29 and eliminate all medical services and practitioners.  
30 Dastardly as it may sound, yet, it is an irrefutable fact  
that both under the medical status quo as well as under  
state medicine, the people have to be sick, to provide  
the Doctors' means of living. Under state medicine,





Davies

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4 instead of the patient paying the practitioner individually,  
5 the government makes the payment but STILL SICKNESS is  
6 THE "PAYMASTER" as the saying is.

7 4. ... Because of this anomaly (sickness  
8 being the Doctors' paying factor) for several centuries  
9 duration, not only it has become an endeared tradition,  
10 but a very difficult one to remove or alter. Why  
11 should sickness (instead of health) be the "paymaster"  
12 of the medical practitioner? There is absolutely no  
13 tangible reason for it being so? Still, because of  
14 this prevailing traditional anomaly, even our medico-  
15 scientific researches, almost totally, are focussed on  
16 the experimental production of DISEASE-PRODUCING DRUGS  
17 and to the determination of their tolerance. There are  
18 scarcely more than a few drugs, among a numberless  
19 multitude of recently developed drugs, which do not  
20 contain toxic and bacterial substances. A goodly number  
21 of them are just barely diluted to avert fatal culmina-  
22 tions. The result has been the unproportionate increase  
23 of diseases of all kinds and almost the total obliteration  
24 of health. By continuing the present decline in health,  
25 or even by enacting a State medicine in its stead, I  
26 feel certain that the objectives outlined in Your  
27 Commission's Code P.C. 1961-883 (of making Canada a  
28 healthier country) will never materialize... Our people  
29 "have" to become sick to sustain the practice of  
30 medicine, either under the continuation of the medical  
status quo, or under state medicine, therefore, socialized  
medicine appears to be THE ONLY SOLUTION IN SIGHT.

5. ... In order to substantiate the provisions  
of objectives of the P.C. 1961-883 Code and to lay the







Davies

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foundations of a healthier era for Canada, I humbly submit, that the Government at Ottawa enact a Bill and make provisions for the establishment of a non-compulsory Socialization of medical, dental, and other auxiliary services and practices by arranging that all practitioners, M.D.s, dentists, Osteopaths, Chiropractors, Naturopaths etc. also nurses, physio-therapists, be totally subsidized to receive a yearly stipulated salary, primarily based on the practitioners' highest Income Tax returns' records, thus leaving no room for complaint or conjecture, free from taxation and paid only to those, who have entered in this government measure. Those desiring to remain outside, may be allowed to do so, also those taxpayers, desiring to be exempted, will be allowed so to do. A number of practitioners or nurses, may be assigned to a portioned area or population, according to their medical needs.

6. A mutually agreed salary is designated to be paid to those who have agreed to join this scheme; as aforesaid, this salary is based on the highest income tax return record of the practitioner. This is for the commencement of this measure's enactment, but as things begin to take shape under socialized medicine, remuneration increases in favour of those who have rendered the greatest service to the largest number of their panels. Those practitioners who have utterly failed, regardless of their educational or professional background, are removed and placed in less responsible positions and replaced by more competent ones, available at the time.





Davies

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4 7. Research institutions, clinics and drug  
5 manufacturers should be advised to pay more attention  
6 to remedies and drugs, devoid of bacterial and toxic  
7 contents, especially to the ones, possessing curative  
8 properties being encouraged and preferred. Better to  
9 depend on a non-toxic and safer agency, even if it is  
10 not as fast acting as unsafe and toxic drugs, which  
11 have made Canada unhealthy.

12 8. As for its system of financing,  
13 I humbly submit that direct selective taxation be  
14 instituted, in a contributory basis, so that those  
15 desiring to remain out may have the option of being  
16 exempted. Likewise any practitioner of medicine, who  
17 disagrees with it and prefers to remain in private  
18 practice, may do so, but such practitioners should  
19 receive no remuneration from this scheme, whatsoever.

20 9. Under our status quo of medical practice  
21 the practitioners alone benefit, the public does not,  
22 as the public health has been in continuous decline.  
23 State Medicine will not alter this condition; e.g.  
24 improving the health will still be neglected. The use  
25 of pathogenic agencies for treating human ailments not  
26 only is contrary to rational reasoning, but highly  
27 dangerous too. My forty-five years of naturopathic  
28 practice has convinced me that there is absolutely  
29 no need for resorting to the use of toxic and bacterial  
30 medicine. Under straight socialized medicine, I assure  
you, Canada will become a very healthy nation, mean-  
while the practitioners will be happy for having con-  
tributed to making the country so.





7. The same institution, clinics and drug  
 organizations should be asked to pay more attention  
 to research and drugs, and to hospital and clinic  
 work, especially to the ones, possibly, that  
 are being encouraged and supported. Better to  
 depend on a non-toxic and safer drug, even if it is  
 not as fast acting as insulin and other drugs, which

8. As the level of thinking,  
 I think, about that aspect of research is  
 limited, in a contradictory sense, so that  
 desire to remain out may have the effect of being  
 expressed. However any practitioner of medicine, who  
 disagrees with it and prefers to remain in private  
 practice, may do so, and such a restriction should  
 receive no remuneration from this scheme, whatever.  
 9. Under our system of medical practice

the practitioners alone benefit, the public does not,  
 as the public health has been a continuous decline.  
 State medicine will not enter this competition; e.g.  
 in the health will still be restricted. The  
 of economic agencies for health human interests  
 will be contrary to national interests, and health  
 will be lost. By twenty-five years of independence  
 practice has developed so that there is a  
 much less resorting to the use of toxic and hazardous  
 drugs. Under that, as for other countries, I assume  
 that Canada will have a very high position, and  
 that the practitioners will be happy for the case



Davies

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Thank you, Mr. Chairman and if there are any questions to be asked I will be glad to answer them.

THE CHAIRMAN: The Medical Liberty League, what is your membership in that league?

DR. DAVIES: At the present time we have not too many of them, we have only about 104 and it is chiefly in Toronto, in this neighbourhood.

COMMISSIONER VAN WART: Are they all naturopaths?

DR. DAVIES: No, mostly lay people, there are only two naturopaths.

COMMISSIONER STRACHAN: Dr. Davies, many years ago it was wisely stated that medical science strives to eliminate the need for its own existence. I think the medical world is proud of that fact. I might also suggest that there is scriptural admonishment regarding the judgment of others and yet, to use your own words, you have made a dastardly judgment of the medical profession or, I might say, I think it is a libellous accusation against the medical profession collectively and individually. Does this same accusation apply to dentistry?

DR. DAVIES: To dentistry?

COMMISSIONER STRACHAN: Yes?

DR. DAVIES: Well, I suppose so long as sickness or disease remains the pay factor I cannot see how any practitioner of any kind, I mean, taking it in general, could ever devise ways and means of eliminating the existence of sickness because that would mean automatic





Davies

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4 elimination of their practice.

5 COMMISSIONER STRACHAN: Then why is  
6 the dental profession endorsing fluoridation of water  
7 supplies which would reduce the amount of dental  
8 attention necessary by 60% if that is their attitude?

9 DR. DAVIES: Allow me to take exception  
10 to that because I do not believe that fluoridation does  
11 reduce the existence of dental caries or anything else.

12 COMMISSIONER STRACHAN: Then, I  
13 wonder if you will believe me when I say that I personally,  
14 and I am sure that the vast majority of my confreres  
15 in dentistry, find a greater thrill and satisfaction in  
16 examining time after time a mouth and finding that no  
17 attention is necessary and when attention does become  
18 necessary it is a matter of grave concern and disappoint-  
19 ment. Would you believe me when I said that?

20 DR. DAVIES: Well, I certainly do.  
21 The only thing is, still I maintain -- pardon me for  
22 being insistent on this -- but I cannot see how any  
23 human being can become so public minded and unselfish  
24 as to work for the deliberate elimination of all ailments  
25 including dental disease because I believe that a much  
26 healthier condition can be established if socialized  
27 medicine was adopted.

28 COMMISSIONER STRACHAN: That would  
29 be open for proof and debate. The Chairman has referred  
30 to your Liberty League, have you a constitution or  
anything?

DR. DAVIES: Yes, we are incorporated  
and we have a Dominion Charter.







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TORONTO, ONTARIO

Davies

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4 COMMISSIONER STRACHAN: On more than  
5 one occasion such things have been asked for, would  
6 you care to give a copy of that constitution and the  
7 aims and objectives of your Association to the secretary?

8 DR. DAVIES: Yes, I have not it right  
9 here now but the secretary has it and we have been  
10 incorporated since 1927.  
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one occasion all things have been asked for, would  
you care to give a copy of that constitution and the

and the of copies of your Association to the secretary

Mr. LAMBERT: Yes, I have not it right

here now but the secretary has it and we have been

incorporated since 1927.

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Davies

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COMMISSIONER STRACHAN: The term  
"liberty" when used in respect to your suggestion that  
people be assigned to certain places and positions and  
that others be removed and placed in less responsible  
positions hardly fulfils my idea as a native Canadian  
of the democratic methods of our country. It would  
seem that you would create a multitude of Siberias in  
Canada by forcing people to ---

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THE CHAIRMAN: Dr. Strachan, I am going  
to use the prerogative I have as the Chairman to say  
that a person has the right to come before this Commission  
to put forward his views. Whether we accept those views  
or not is a matter for us. Whether they are views that  
should appeal to us or not, there is the right of the  
citizen to appear before this Commission. That is why  
we are holding public hearings and it cannot be our  
function to educate or to change the opinion of those  
who appear before us.

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DR. DAVIES: Would you allow me, Mr.  
Chairman, to say a word? I am personally very, very  
concerned with the health conditions that prevail in our  
country. We have the unfortunate reputation of being one  
of the sickliest countries in the world despite the fact  
that we have the widest spread and very extensive sanitary  
conditions, lack of malnutrition and also, I may add, an  
abundance of practitioners of all types. Despite all  
these things, there are countries in the world where  
medical services are practically absent and the people  
are healthier than we are. Our hospitals and health  
institutions are filled to capacity ---







Davies

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THE CHAIRMAN: Now, Dr. Davies, by the same token that you have the right to appear before us to give your views as to the matters which are within our competence as delineated in the Order in Council, we are not a forum for just speech-making. I think that is what you are undertaking to do now.

COMMISSIONER STRACHAN: Mr. Chairman, may I ask your toleration and forbearance and that of the other members of the Commission to ask a few questions?

THE CHAIRMAN: If they are relevant to the brief.

COMMISSIONER STRACHAN: Very well. I hope they will be pertinent to dentistry, since Dr. Davies has very definitely suggested that "all practitioners, M.D.'s, dentists, osteopaths, chiropractors, naturopaths, etc., also nurses, physiotherapists, be totally subsidized to receive a yearly stipulated salary..."

I, too, have spent almost 45 years trying to learn a little about dentistry, but I must admit I more and more realize ---

THE CHAIRMAN: Dr. Strachan, may I suggest you put a question and let's have no more of this historical reviewing of one's qualifications or disqualifications.

COMMISSIONER STRACHAN: And I am sure of this statement, that Dr. Davies has put some thought and study in this. How would the salary of a dentist be arrived at?

DR. DAVIES: Well, I think that ---





Davies

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COMMISSIONER STRACHAN: And would there be a pension?

DR. DAVIES: No. The submission I have made in the brief is already clear. Every one of the practitioners has already filed income tax returns every year. Now, the compensation will be the highest income tax record of the practitioner. That is my submission.

COMMISSIONER STRACHAN: You have made suggestions, and as has often been suggested by this Commission, we would like to know the methods of implementation. Who would pay the rent for the office, who would pay the rent for the equipment in an office, who would decide what that rent should be, considering that there will be old and new equipment in an office varying in odd-thousand dollars-worth to several thousand dollars-worth. How would you decide that?

DR. DAVIES: Well, the doctors, the dentists, M.D. or specialist, at the present time are paying from their own income and so it would be from their own salary, and I suggested that whatever the salary is should be tax-free.

COMMISSIONER STRACHAN: Would that salary have to cover all the expense of carrying on that practice?

DR. DAVIES: Doesn't it do it at the present time? Nobody helps you to buy your equipment. It is your income that provides it.

COMMISSIONER STRACHAN: Would that all be included?

DR. DAVIES: Naturally.







Davies

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COMMISSIONER STRACHAN: And would the service rendered to the patient be dependent on that salary?

DR. DAVIES: Naturally.

COMMISSIONER STRACHAN: Who would decide what hours would be spent in an office?

DR. DAVIES: That is a mutual agreement between the Government and the practitioners, that they would make regulations.

COMMISSIONER STRACHAN: Who would check that these hours would be spent?

DR. DAVIES: Those are details that would have to be left to the specialists. For instance, a committee will be appointed and the committee will look after these things.

COMMISSIONER STRACHAN: Who will take care of patients after-hours and at weekends?

DR. DAVIES: Well, the practitioners will be apportioned to work in turns, so many hours so-and-so, so many hours somebody else, and so forth, the same as they do at the present time.

COMMISSIONER STRACHAN: Who will decide whether I should do sloppy, haphazard, hurried work with little mental or physical exertion, or whether I should work slowly and cautiously and with careful attention to detail with interest and concern in and for the patient under the stress and strain, mentally and physically?

DR. DAVIES: Well, at the present time, Doctor, you are using those discretions and you are entrusted with the task of looking after the welfare of



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the patient. So that please do not ever think that I am insinuating that our doctors are selfish or not enough public-minded or anything of the kind. The only thing I am suggesting is that sickness being as it is, it is impossible for them to work continuously and steadfastly for a method of complete elimination of sickness, of diseases.

COMMISSIONER STRACHAN: Then further recognizing the fact that certain dental work can be done at a total fee much less than another way of doing that work, who decides on the method or type, assuming that the Government is paying for it?

DR. DAVIES: Well, I presume, at the present time, there are a number of medical practitioners who have a number of unpaying patients, who cannot afford to pay, and with this you will be better off, there will be none of that. You will be better off than before.

COMMISSIONER STRACHAN: Not if it is costing me money to pay for that.

DR. DAVIES: Yes, but that salary will be the highest income you have ever received, the biggest money you have ever made.

COMMISSIONER STRACHAN: Do you feel that such a method would encourage the youth to enter the professions?

DR. DAVIES: I am sure of that; and anyone who did allow me to enter in the medical field with no other object in mind but to make plenty of money is not, in my opinion, a good practitioner. The majority of our practitioners are unselfish, devoted, dedicated







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Davies

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men and women and they didn't want to be wealthy, but  
they can't help it.

THE CHAIRMAN: Thank you, Dr. Davies.

DR. DAVIES: Thank you very much.

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THE SECRETARY: Mr. Chairman, we will now hear from the Ontario Retail Pharmacists' Association, which will be Exhibit 258, and from Prescription Services Incorporated, Exhibit 259. Both of these organizations will be represented by Mr. Walker, their counsel; both will be presented individually.

--- EXHIBIT NO. 258: Submission of the Ontario Retail Pharmacists' Association.

--- EXHIBIT NO. 259: Submission of Prescription Services Incorporated.

SUBMISSION OF THE ONTARIO RETAIL  
PHARMACISTS' ASSOCIATION.

a n d

SUBMISSION OF PRESCRIPTION SERVICES INCORPORATED

Appearances: Mr. Richard R. Walker, Q.C.,  
Counsel  
Mr. Stanley Turner  
Mr. William A. Wilkinson

MR. WALKER: Mr. Chairman, for the record, my name is Richard R. Walker, Q.C., of Windsor. With me is Mr. Stanley Turner, on my left, past-President of the Ontario Retail Pharmacists' Association from London, Ontario and beside him is Mr. William A. Wilkinson of Windsor, President of Prescription Services.

Mr. Turner will be presenting the brief for the O.R.P.A., and I request that they be presented independently.

THE CHAIRMAN: Yes, whatever procedure you wish to follow we will accept, and then we will have







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Walker

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a discussion of the two together or separately?

MR. WALKER: May I suggest we deal  
with O.R.P.A. separately and separately with Green  
Shield.





Turner

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MR. TURNER: SUMMARY AND MAIN CONCLUSIONS

1. In the matter of National health insofar as the compounding and dispensing of drugs is concerned, the Ontario Retail Pharmacists' Association supports the recommendations and statements of policy contained in the brief of the Canadian Pharmaceutical Association. As the Canadian Pharmaceutical Association has set out its views in this respect in full we do not propose to make further reference thereto in this submission.

2. Notwithstanding that the Canadian Pharmaceutical Association expresses the views of the profession of pharmacy in its national or Dominion-wide sense, nevertheless the O.R.P.A. (which is the largest single Provincial Retail Pharmacists' Association engaged in serving the largest section of the population in Canada) feels it appropriate that it should make its own presentation to this Commission and express its own views on the problems with which its members are most familiar and most concerned, namely the distribution of prescribed pharmaceuticals in the Province of Ontario. In summary, our views, recommendations and conclusions are as follows:

(a) In another part of this submission will be found a detailed account of the problems which face the practice of pharmacy in Ontario today and without detailed consideration at this point these problems are briefly as follows:

(i) The extended use of prescription







Turner

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4 drugs in the field of health as a  
5 result of the improvement of health  
6 techniques and research for drugs;  
7 (ii) The enlargement of the availa-  
8 bility of drugs to the public to  
9 ensure to the public the maximum  
10 benefit arising from the continued  
11 research and development of drugs;  
12 (iii) Public concern with the matter  
13 of drug prices;  
14 (iv) The continued maintenance of  
15 the standards of professional care  
16 exercised in the compounding and  
17 dispensing of drugs by legally quali-  
18 fied pharmacists in the interest of  
19 public safety; together with its  
20 corollary problem of policing of  
21 The Pharmacy Act so as to ensure that  
22 unqualified and unlicensed persons  
23 do not engage in the compounding and  
24 dispensing of prescription drugs to  
25 the detriment of public safety;  
26 (v) The difficulty facing the  
27 retail pharmacist in maintaining a  
28 reasonable profit level in the face  
29 of -  
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(I) Discount stores;

(II) Cutrate stores;

(III) Mail order marketing of  
drugs;





Turner

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(IV) The competition of non-pharmacy outlets in the sale and distribution of drug sundries;

(vi) The need for enlargement of the number of persons entering the practice of the profession of pharmacy with the obvious enlargement of the numbers graduating therefrom, particularly in face of the ever-increasing necessity for professional training in the compounding and dispensing of the multitude of new drugs brought into being through extended research;

(vii) Other external influences upon pharmacy including physician dispensing, dispensing through hospitals, the Department of Veterans' Affairs and other Federal agencies, Provincial and Municipal Welfare, nursing homes, voluntary health agencies and union and industry dispensaries.

(b) We submit that it is not in any way in dispute that pharmacy is a recognized profession whose members must be skilled and trained in education, both theory and practice, and we do not make this submission simply in support of the position professionally of pharmacists, but as a statement in the public interest.







Turner

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3 It hardly need be pointed out that the compounding and  
4 dispensing of prescription drugs must, of course, be  
5 done by skilled professional people in the interest of  
6 public safety for the compounding and dispensing of  
7 prescription drugs by non-professional and non-skilled  
8 people may well result in death or injury. A more  
9 detailed comment in connection with this may be found  
10 elsewhere in our submission quoting at length from the  
11 statement made by Dean Hughes, Dean of the Faculty of  
12 Pharmacy of the University of Toronto before the Select  
Committee on Drugs of the Province of Ontario.

13 Any solution other than the compounding  
14 and dispensing of drugs by either a pharmacist or physi-  
15 cian necessarily involves providing skilled personnel  
16 with the same levels of education both in theory and in  
17 practice that a pharmacist now has and it is clear that  
18 such would not represent any reasonable solution to the  
19 problem for what is being done is to substitute one form  
20 of trained professional personnel for another form of  
21 trained professional personnel. In the result we think  
22 and submit that there is not in fact any feasible  
23 substitute to the pharmacy as the health centre of the  
community and as the centre for the distribution of  
24 prescription drugs.

25 The pharmacy has, of course, always  
26 been the health centre of the community and the centre  
27 of distribution of prescription drugs but it has assumed  
an ever-increasing role for two reasons:

28 (a) Firstly - the large increase of  
29 population including in that respect its tendency for  
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It is also pointed out that the purpose of the  
the purpose of the organization is to serve the  
done by other people and people in the interest of  
public safety for the purpose of and dispensing of  
prescription drugs by non-physicians and non-physician  
personnel may well result in death or injury. A more  
detailed comment in connection with this may be found  
elsewhere in our submission dated at length from the  
statement made by your staff, one of the results of  
the review of the activities of the various bodies the subject  
concerned in view of the knowledge of the

Any doubt as to the soundness  
and dispensing of drugs by either a pharmacist or physi-  
cian necessarily involves providing skilled personnel  
with the same levels of education both in theory and in  
practice that a physician would have and it is clear that  
such would not represent any reasonable addition to the  
problem for which is being done to be substituted one form  
of medical professional personnel for another form of  
trained professional personnel. In the result we think  
and admit that there is not in fact any feasible  
substitute to the physician as a central figure of the  
community and as the center for the distribution of

the community, always  
been the case of the community and the health  
of the community of people, for it has assumed  
an ever-increasing role for the community  
(a) First - the fact that the  
organization in the community is the only



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concentration, such as in urban areas, which, in itself has given rise to the greater utilization of drugs; and

(b) Secondly - the enormous advances in health techniques and drug research with the consequent multitude of drugs that have been brought into being and which have proved to be so important to the public in the field of health, particularly in the past 25 years.

In a similar manner to any profession, students will not be attracted to a profession which does not promise a reasonable remuneration for the professional skills employed and the pharmacy profession today faces issues and problems which have had an impact financially so that it has been difficult for the retail pharmacist to ensure that he can operate his pharmacy at reasonable profit levels; and this very fact has become plain and apparent generally as can be seen by the decreasing numbers of persons who enter the Faculty of Pharmacy and who graduate from it into the ranks of the profession, notwithstanding the great need for a larger number of professionally trained pharmacists.

Some solutions to the problems which we have outlined above have been offered, but in our opinion none of these solutions really succeed in attacking the fundamental problem and bringing it to a conclusion. For instance -

(a) We submit that it is true that the reduction of the cost of drugs will cause an increase in the utilization of drugs for the public which we believe to be in the public interest. However, the various







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methods that have been proposed for drug price reduction have not, in fact, had any real result and we are extremely doubtful if they will result in substantial and continued price reduction. In any event at the retail level the average retail pharmacist finds it sufficiently difficult to maintain a reasonable profit level today without facing the problem of having to lower his prices so that he will not be able to operate either profitably or efficiently;

(b) It has been suggested also that prescribing, by use of generic names, will succeed in both price reduction and perhaps wider utilization, but there are specialized problems of quality control, drug toxicity, physician education, similarity of names, multi-syllable chemical description and drug substitution in a manner not contemplated by the physician prescribing the drugs in the first instance; in addition, (and these factors previously stated are relevant to the prescription of single chemical generic substances) there is the special problem where the drug prescribed is, in fact, composed of two or more generic substances each having a single generic name, but the drug itself does not have a common generic name which is capable of being specified to indicate the drug itself; in such a case, such a drug for obvious reasons must be named and as a consequence usually becomes a trademark name and the circle is then complete. We think it reasonably evident that generic name prescribing will not have the results claimed for it.

(c) The same result occurs so far as the proposal for bulk purchasing is concerned. Bulk

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purchasing may be effective if, in fact, the pharmacist knows every item that any physician to whom a patient may go will prescribe; this is an obvious impossibility and as a consequence the pharmacist must stock a multitude of items which he can little afford to purchase upon a bulk basis against the risk that its potency will expire before his inventory is properly liquidated. Bulk purchasing will, of course, work in specialized institutional situations where there is a heavy concentration on particular types of drugs, but applied across the retail pharmacy profession at large it is not capable of effecting any substantial reduction in cost.

(d) Price reductions can be afforded, of course, through discount stores and mail order operations. So far as discount stores are concerned, these are keyed to certain specialized operations requiring large volume of traffic in heavily populated urban areas, but the deteriorating effect upon less heavily populated urban areas is very great, so much so that it will tend to drive down the level of retail pharmacy profit (which is not high at this time) to a point where it may become extremely difficult for the retail pharmacist to maintain his business; so far as less heavily populated areas are concerned, the discount store is, of course, no answer at all. Mail order operations represent a trend that has caused considerable unrest amongst pharmacists generally and is a type of operation that our Association does not support; we are of the opinion that such a method of dispensing prescriptions is detrimental to the public for the reasons set out in detail elsewhere in







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our submission.

It might well be said that it is reasonably obvious that a retail pharmacy of the normal type must have considerable difficulty in operating at a profit if its operations are entirely restricted to its professional side or the compounding and dispensing of drugs. This is an admitted fact for, more particularly many years ago and not quite so definitely today, the pharmacist operating solely on a professional level was unable to be remunerated in a manner commensurate with his professional training; as a consequence, the pharmacist in answer to public demand entered into what has been called the drug sundries field and the bulk of the business of the retail pharmacy today consists of drug sundries. Nevertheless, the profit level of drug sundries is quite low and when one considers the high cost of the necessary professional assistance in the dispensary the overall average of profit for the owner of the pharmacy is not really comparable to other persons who have been required to take like professional training.

3. It will be observed from what we have said herein that retail pharmacy today faces grave and important problems which, if not solved, will have serious consequences for the public and the profession of pharmacy in the field of prescription drugs. How then can the problems of retail pharmacy be solved? In our submission it is important that these problems do be solved for the retail pharmacy is the only practical centre of distribution to the public for prescription drugs. Thus, if the retail pharmacy as we know it today



It will be said that it is

receptively... must have... it is... its... of drugs... fairly many years ago and not quite so definitely today... the pharmacist operating solely on a professional level... was unable to be remunerated in a proper manner... with his professional training as a consequence, the... pharmacist in answer to public demand entered into what... has been called the drug business field and the risk of... the business of the retail pharmacy today consists of... drug sundries. Nevertheless, the profit level of drug... sundries is quite low and when one considers the high... cost of the necessary professional assistance in the... dispensary the overall average of profit for the owner... of the pharmacy is not really comparable to other persons... who have been required to take like professional training... it will be observed from what we

have said... retail pharmacy today faces grave... and two other problems which, if not solved, will have... serious consequences for the public and the profession... of pharmacy in the field of prescription drugs. How then... can a pharmacist solve these problems? In one... solution is to be found in the fact that these problems do not... solve for the retail pharmacy is the only practical... center of distribution to the public... of the retail pharmacy as we know it today.



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4 should disappear the centre of health needs of the  
5 community will likewise disappear. These are real and  
6 abiding problems not only for pharmacy as a profession,  
7 but for the public as well who cannot fail to suffer as  
8 a consequence.

9  
10 4. What we have said to this Commission  
11 to this point has been negative in the sense that we  
12 have indicated the problems that face retail pharmacy  
13 and as well that some of the solutions which have been  
14 offered to these problems are not practical or feasible.  
15 In our opinion, however, the Green Shield Prescription  
16 Plan offered by Prescription Services Inc. of Windsor,  
17 Ontario, provides a solution to the problems of retail  
18 pharmacy and the profession of pharmacy in a manner which  
19 provides the public with a wider availability of drugs  
20 and at reasonable cost levels within the reach of the  
21 average person.

22  
23 5. Insofar as retail pharmacy is  
24 concerned we feel that the Green Shield plan embodies  
25 the following benefits:

26 (a) The Green Shield plan will permit  
27 the profession of pharmacy to continue its valued and  
28 important services to the public while maintaining its  
29 economic capacity to sustain the profession at a profes-  
30 sional level.

(b) A direct consequence of the improve-  
ment in the economic position of the pharmacist will  
naturally, we submit, be an increase in the number of  
persons who will wish to enter the profession of pharmacy  
and a consequent direct increase to the number of pharmacy





should disappear the centre of health needs of the community will likewise disappear. These are real and abiding problems not only for pharmacy as a profession, but for the public as well who cannot fail to suffer as

What we have said to this Commission is that this point has been negative in the sense that we have indicated the problems that face retail pharmacy and as well that some of the solutions which have been offered to these problems are not practical or feasible. In our opinion, however, the Green Shield Prescription Plan offered by Prescription Services Inc. of Weyburn, Ontario, provides a solution to the problems of retail pharmacy and the profession of pharmacy in a manner which provides the public with a wider availability of drugs and at reasonable cost levels within the reach of the

Indeed as retail pharmacy is concerned we feel that the Green Shield Plan embodies the following benefits:

(a) The Green Shield Plan will permit the profession of pharmacy to continue its valued and important services to the public while maintaining its economic capacity to sustain the profession at a professional level.

(b) A direct consequence of the improvement in the economic position of the pharmacist will naturally, we submit, be an increase in the number of persons who will wish to enter the profession of pharmacy and a consequent direct increase in the number of persons



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graduates. Such a development is important as there is a need for new members in the profession and this need continues to increase by reason of the extension of new techniques in health and research in drugs and increase in population.

(c) Wider availability of drugs and the consequent increased utilization naturally means an increase in the number of prescriptions dispensed by retail pharmacy and the Green Shield studies indicate this to be the case. It seems clear that a physician is more disposed to prescribe the needed drug without regard to cost when he knows that it will not entail economic hardship upon his patient to have it dispensed.

(d) Uncollectable accounts for prescriptions dispensed are eliminated as all payments for prescriptions dispensed are made directly through the Green Shield plan to the member pharmacy.

(e) The public concern about drug prices will be completely resolved by the Green Shield plan because the cost of drugs will be a budgetary cost on a constant level rather than a financial uncertainty in any period.

(f) There is clearly no satisfactory alternative to the distribution of prescription drugs except through existing retail pharmacies without incurring enormous and unwarranted costs. The Green Shield plan, however, takes advantage of and operates through retail pharmacies in the traditional manner thereby sustaining the position of the retail pharmacy at the same time ensuring that all prescription drugs that are





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made available to the public are provided in a safe, professional and convenient manner.

6. A paramount consideration, however, is the public concern to be provided with prescription drugs when the need arises and within its economic capacity to pay for the needed drugs. In our opinion the Green Shield plan resolves this matter of public concern for it provides the widest availability of prescription drugs for the public and at reasonable cost levels.

7. We have supported the Green Shield plan from its inception having provided it with a grant of \$3,000.00 in support of these studies and in addition at our conference in 1961 as an Association we endorsed wholeheartedly the Green Shield plan. We therefore recommend to this Commission full and wholehearted support of the Green Shield plan.

8. ALL of which is respectfully submitted by the ONTARIO RETAIL PHARMACISTS' ASSOCIATION.

THE CHAIRMAN: Thank you very much, Mr. Turner. Now, I understand you wish to have what discussion will take place with respect to this submission at this time?

MR. TURNER: Yes sir, if you would.

THE CHAIRMAN: Professor Firestone?

COMMISSIONER FIRESTONE: Mr. Turner, on page 1, Recommendation 1, you say that your Association supports the recommendation and statements of policy contained in the brief of the Canadian Pharmaceutical Association. Later on in your summary and recommendations





is available to the public and otherwise in a sale,

is the public concern to be provided with prescription

drugs when the need arises and within its economic

capacity to pay for the needed drugs, in our opinion

the Government should plan reserves this matter is such

concern for it over the widest availability of

prescription drugs for the public and at reasonable

cost levels.

4. We have supported the Green Shield

plan from its inception having viewed it with a great

of \$1,300,000 in support of these studies and in order

at our conference in 1961 as an association of members

thoroughly the Green Shield plan, we therefore

recommend to this Commission that it be immediately

accepted at the Green Shield plan.

8. All of which is respectfully

submitted by the Ontario Health Insurance Board.

THE CHAIRMAN: I am very much

in agreement with what you have said

the decision will take place with respect to this subject

from at this time.

MR. CHAIRMAN: Yes, and you will

be a member of the Ontario Health Insurance Board?

MR. CHAIRMAN: Yes, you are a member of the

Ontario Health Insurance Board and are a member of the

Ontario Health Insurance Board and are a member of the

Ontario Health Insurance Board and are a member of the



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you say you endorse the Green Shield plan, in paragraph 4 on page 8. I take it from this endorsement you are in favour of a plan which would provide for the prepayment of prescribed drugs?

MR. TURNER: We would be in favour of a plan that would provide prepayment of prescribed drugs.

COMMISSIONER FIRESTONE: I take it that the principle that is followed in the Green Shield plan, whereby people pay premiums for participation in such a plan, is acceptable to you?

MR. TURNER: That is right.





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COMMISSIONER FIRESTONE: Now how would the hospital drugs under such a plan be paid for by people who cannot afford to pay for such drugs?

MR. WALKER: Mr. Chairman, I hesitate to interrupt the Commissioner, but may I suggest that I am sure that question will be developed quite fully by Mr. Wilkinson in his Green Shield presentation and may I suggest that it be left for discussion by him? He is perhaps more familiar with it.

COMMISSIONER FIRESTONE: I have no objection to leaving a discussion of the Green Shield Plan to the gentleman who is presenting it to us, the Green Shield Plan.

What we are here concerned about is a rather wider plan than the Green Shield Plan. As I understand it, the Green Shield Plan is a plan which provides for the prepayment of the purchase of drugs, prescribed drugs for those who can afford to pay the premiums.

What I am asking the Ontario Retail Pharmacists' Association is whether they are in favour of a broader plan that goes beyond the Green Shield Plan. As I understand, you are in favour of a broader plan that makes prepayment of drugs possible for all the people of Ontario. Is that correct?

MR. TURNER: That is correct sir.

COMMISSIONER FIRESTONE: Therefore, the question as to how one could arrange for payment for those that cannot afford to pay the premiums under the Green Shield Plan is one that you may have some comments





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by Mr. Wilkinson in his Green Shield presentation and  
may I suggest that it be left for discussion by him?  
He is perhaps more familiar with it.  
COMMISSIONER FINCH: Mr. I have no  
objection to leaving a discussion of the Green Shield  
Plan to the gentleman who is presenting it to us, the  
Green Shield plan.  
that we are here concerned about is  
a rather wider plan than the Green Shield Plan. As I  
understand it, the Green Shield Plan is a plan which  
provides for the prepayment of the purchase of drugs,  
prescribed drugs for those who can afford to pay the  
cost.  
What I am asking the Committee to do  
is to decide whether or not it is in favor  
of a broader plan that goes beyond the Green Shield  
Plan. As I understand, you are in favor of a broader  
plan that makes prepayment of drugs possible for all  
people of our country. Is that correct?  
Mr. Finch: That is correct.  
COMMISSIONER FINCH: Therefore,  
the question as to how one could prepay for payment for  
those that cannot afford to pay the premium when the  
Green Shield Plan is one that you may have some comment



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4 on, and my specific question is whether your Association  
5 would endorse payment of the premium, or whatever  
6 arrangements were made for payment by the State for the  
7 indigent, the medically indigent requiring drugs?

8 MR. TURNER: We feel that the people  
9 who are at the present time unable to secure drugs by  
10 their own means, and that is people for which  
11 Governmental bodies have already accepted the responsi-  
12 bility, that the Government would still pay on their  
13 behalf, but we do not feel that the average citizen,  
14 the average family is unable to pay voluntarily for  
15 their drugs over the budgeted cost.

16 COMMISSIONER FIRESTONE: Well I think  
17 what you are saying, sir, is that those that can afford  
18 to pay the premiums should pay them, and those that  
19 cannot afford to pay the premiums should have the  
20 premium, or its equivalent, paid by the State. Do I  
21 understand this correctly?

22 MR. TURNER: I would think that would  
23 be the only way that could be possible.

24 COMMISSIONER FIRESTONE: Thank you  
25 very much. May I now turn to page 3 of your recommenda-  
26 tions, number 2, subparagraph 7 on the second line on  
27 the top of the page 3. In the second line you speak  
28 of various external influences upon the pharmacy and  
29 one of those influences that you mention in this  
30 paragraph are physicians dispensing drugs. Can you  
elaborate on what you mean?

MR. TURNER: We are not concerned  
with physicians dispensing drugs. We are merely stating  
external influences that have an affect on the amount of



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on, and my specific question is whether your association would endorse payment of the premium, or whatever arrangements were made for payment by the state for the individual, the medically indigent requiring drugs?

MR. TURNER: I feel that the people who are at the present time unable to secure drugs by their own means, and that is people for whom Governmental bodies have already accepted the responsibility, that the Government would still pay on their behalf, but we do not feel that the average citizen, the average family is unable to pay voluntarily for their drugs over the budgeted cost.

COMMISSIONER: Will I think that you are saying, sir, is that those that can afford to pay the premium should pay them, and those that cannot afford to pay the premium should have the premium, or its equivalent, paid by the state. Do I understand this correctly?

MR. TURNER: I would think that would be the only way that could be possible.

very much. May I now turn to page 4 of your recommendations, number 2, subparagraph 1 on the second line on the top of page 3. In the second line you speak of various external influences upon the pharmacy and one of those influences that you mention in this paragraph are medicines requiring drugs. Can you elaborate on what you mean?

MR. TURNER: We are not concerned with private medicine. We are merely aware of external influences that have an effect on the state.





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4 drugs dispensed by the pharmacists. The average  
5 pharmacist, I would think, is equipped to dispense  
6 more prescriptions a day than he is at present doing,  
7 and if he were dispensing the full requirements, the  
8 adequate number of prescriptions that were being prescribed  
9 he would be in a position to better his position  
10 financially where it would enable him to receive a  
11 better margin of profit. The profession would then  
12 probably be able to entice more people into the  
13 profession.

14 COMMISSIONER FIRESTONE: Is your  
15 point sir, or is it not that physicians dispensing drugs  
16 in Ontario, that this practice is either common or  
17 rare? What is the factual situation in Ontario?

18 MR. TURNER: We believe that there is  
19 a fair number of prescriptions dispensed by physicians.

20 COMMISSIONER FIRESTONE: And are  
21 physicians paid for the dispensation of such drugs,  
22 by the patient?

23 MR. TURNER: I would assume that in  
24 one manner or another, the drug, I would assume would  
25 have to be paid for in some manner.

26 COMMISSIONER FIRESTONE: And you would  
27 say that this practice, to your knowledge, is fairly  
28 widespread?

29 MR. TURNER: I wouldn't say it was  
30 widespread. There is a considerable number of physicians  
dispensing.

COMMISSIONER FIRESTONE: I won't  
discuss the semantics between considerable and wide-  
spread. I will leave this to your own judgment. May I





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...I would think, is supposed to be ...  
...more prescriptive ... than he is at present ...  
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3 ask you in this connection whether you know of cases  
4 in the Province of Ontario where doctors, practising  
5 physicians that is, have a financial interest in  
6 pharmacies operating in the Province?

7 MR. TURNER: I haven't any concrete  
8 information on that sir. I wouldn't care to make a  
9 comment on that.

10 COMMISSIONER FIRESTONE: Have you  
11 any knowledge of pharmacists renting space in doctor-  
12 owned buildings where the rental for this space is  
13 provided for in the form of a fixed rental, plus a  
14 percentage of gross sales of that particular pharmacy  
or pharmacist?

15 MR. TURNER: You ask me if I had any  
16 knowledge of that?

17 COMMISSIONER FIRESTONE: Or your  
18 Association has any knowledge. You are speaking for  
your Association.

19 MR. WALKER: I suggest, Mr. Commissioner,  
20 that probably the best answer to that is I don't think  
21 the Association, as such, has ever considered that  
22 problem. I doubt very much if it has any specific  
23 knowledge of it.

24 MR. TURNER: That would be my answer.  
That we haven't gone into it as an Association.

25 COMMISSIONER FIRESTONE: May I now  
26 turn to paragraph (b) on page 5 in which you state,  
27 Mr. Turner, and this is the last sentence in that  
28 paragraph and I quote: "We think it is reasonably evident  
29 that generic name prescribing will not have the results  
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and you in this connection whether you know of cases  
in the Province of Ontario where the cases, practicing  
physicians there, have a financial interest in  
pharmaceuticals operating in the Province  
of Ontario. I haven't any concrete  
information on that point, I would have to make a  
search of the records. Have you  
any knowledge of pharmaceuticals operating in Ontario  
owned buildings where the rental for this purpose is  
included for in the form of a fixed rental, this is  
percentage of gross sales of that particular pharmacy  
or pharmacist?  
Mr. TURNER: I don't know if I had any  
knowledge of them.  
Association has any knowledge, you are speaking for  
Mr. TURNER: I don't know, Mr. TURNER:  
that property the fact that it is a fact that  
the Association, as such, has been considered that  
problem, I don't know much if it is any specific  
knowledge of it.  
Mr. TURNER: What would be my answer  
that to have a more definite as an Association,  
Mr. TURNER: I don't know, Mr. TURNER:  
that to have a more definite as an Association,  
Mr. TURNER: I don't know, Mr. TURNER:  
that to have a more definite as an Association,  
Mr. TURNER: I don't know, Mr. TURNER:



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4 claimed for it." What results are you referring to  
5 please?

6 MR. TURNER: Well, many of the --  
7 in many of the previous hearings, I refer to Restrictive  
8 Trade Practices and the Select Committee, it has been  
9 the general assumption that prescribing in generic  
10 terms would reduce the cost of drugs. We, as an  
11 Association, do not feel that this would be a fact in  
12 view of the reasons that we have outlined in the brief  
13 here.

14 COMMISSIONER FIRESTONE: Well now sir  
15 you are a practising pharmacist yourself?

16 MR. TURNER: I am sir.

17 COMMISSIONER FIRESTONE: Are you aware  
18 of one or other particular drug of equivalent quality  
19 which is sold at one price under generic name and at  
20 a higher price under a brand name?

21 MR. TURNER: Well, when we are speaking  
22 of equivalents, I think the word "equivalent" would  
23 have to be clarified.

24 I couldn't say from my experience that  
25 one drug at a high price and one drug at a low price are  
26 equivalents.

27 THE CHAIRMAN: I think Professor  
28 Firestone's question was do you know of any factual  
29 situation that drug "X", being its generic name, and "Y"  
30 being its trade name, being identical ---

COMMISSIONER BALTZAN: And having  
equal potency.

THE CHAIRMAN: Being the identical



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3 article. By identical, have the potency and everything  
4 else

5 MR. TURNER: I would know of two  
6 drugs that were identical in potency.

7 THE CHAIRMAN: I didn't ask about  
8 that. I am asking about is there such a thing as two  
9 drugs, one drug known either by generic name or trade  
10 name, the same article?

11 MR. TURNER: Yes, there are. There  
12 are many.

13 COMMISSIONER FIRESTONE: Well now,  
14 without wanting to go into any detail of the name of  
15 the drug or the price, would you say that from your  
16 knowledge as a practising pharmacist the price of the  
17 brand name drug of equivalent quality would be higher  
18 than that of the drug selling under the generic name?

19 MR. TURNER: Yes, it would.

20 COMMISSIONER FIRESTONE: The Chairman  
21 just suggested perhaps the phrase, a more appropriate  
22 phrase would be identical quality, and I would like  
23 to state my question in that context to make it easier  
24 for you. I take it the answer is ---?

25 MR. TURNER: Yes.

26 COMMISSIONER FIRESTONE: Well now sir  
27 if it is true, and I understood you to say there would  
28 be many such drugs?

29 MR. TURNER: Yes.

30 COMMISSIONER FIRESTONE: Would it not  
be true that if more drugs were sold to the public under  
a generic name, instead of a brand name, it probably





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could pay less for the same drug?

MR. TURNER: It would, yes, providing the pharmacist was willing to accept the legal responsibility of the product that he supplied, and I think first, before the pharmacist can be asked to do that, we must first have some degree of control at the Federal level that will ensure that drugs that are released for sale are in fact drugs that we can rely on as being pure.

COMMISSIONER FIRESTONE: This is a fair suggestion, because we are now saying that there are many drugs that could be sold under generic name at lower price to the patients but that the pharmacist will want to or wish to have certain assurances and protection. I take it one of these protections you have mentioned, and that is the Food and Drug Administration of the Department of National Health and Welfare has a more extensive system of control and verification, et cetera. Would the second assurance to the pharmacist be the Ontario Legislature if they were to pass similar legislation as is now in the process of being considered in Alberta, whereby the retail pharmacist would have the right to do so by law. In other words, the question is this sort of cost reduction could be passed on to the consuming public if certain assurances were provided to the retail pharmacist. Is that your basic stand?

MR. TURNER: That would not apply to compounds. That would apply to approximately 30 drugs possibly in normal use that could be used generically.

A drug that is a compound of two or







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more generic names would almost be impossible to write on a prescription, or for a druggist to interpret them wisely and safely, but the single generic term drug could be used that way.

COMMISSIONER FIRESTONE: Without wanting to go into detail, and appreciating the difficulties that there are some drugs where this can be done, and some where it cannot be done, as far as the number is concerned I take it, from what you are saying sir, that such a system could be developed with co-operation of the Federal and Provincial Governments and the result would be lower drug prices in a certain number of drugs to the consuming public.

MR. TURNER: I don't believe that if all qualifications were brought into being that there would be a substantial decrease in the cost of drugs.

COMMISSIONER FIRESTONE: Whether it is substantial or not sir only experience will show, but as I gather from what you said earlier there are price differentials between brand named drugs and generic named drugs and whatever benefit could be obtained could be passed on to the consuming public.

MR. TURNER: Providing the pharmacist has the protection of the quality and purity of the drug there would be no objection.

COMMISSIONER FIRESTONE: Thank you very much. That is a forthright statement. I appreciate your system in advising us of your views on the subject.

May I now turn to paragraph C on page 6, the second line and you say and I quote:





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"The same result occurs so far as the  
"proposal for bulk purchasing is  
"concerned."

I am just wondering sir whether there isn't a little  
bit of inconsistency if one suggests on the one hand  
that institutions that do bulk purchasing are able to  
get drugs at lower prices, and then if one suggests  
that if bulk purchasing were practised by retail  
pharmacists, they would not obtain lower prices. Could  
you explain to me this situation?

MR. TURNER: Well I believe we said  
here sir, that the bulk purchasing will, of course,  
work in special institutional situations where there  
is heavy concentration of a particular type of drug.  
Where an institution knows they are going to use a large  
quantity of one particular drug, then they can make  
an attempt to buy that in bulk or quantity purchase.

As far as the retail pharmacist is  
concerned, we do not know what we are going to be called  
upon to supply and so we might make an attempt to buy  
in quantity on a bulk purchase and not have the  
opportunity to use the medication and therefore it would  
go out of existence through the loss of potency or  
age or deterioration.







CH/EE/ss2

Turner 9562

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3  
4 COMMISSIONER FIRESTONE: Yes, and  
5 furthermore, if you may not want to hold large inventories  
6 and this is a very sensible and business-like approach.  
7 Would you say from your experience there are certain  
8 drugs that are more commonly used than others and the  
9 demand is fairly continuous?

10 MR. TURNER: Oh, we buy certain drugs  
11 in large quantities.

12 COMMISSIONER FIRESTONE: Could we go  
13 a little further and, let us say, if retail pharmacists  
14 were to band themselves together into a wholesale coopera-  
15 tive and buy by large quantities, would that not help  
16 them to do more bulk purchasing and as a result get lower  
17 costs which they, in turn, could pass on to the consuming  
18 public?

19 MR. TURNER: There are some problems  
20 in a group buying, there is a problem in any group of  
21 warehousing, administration costs, collecting accounts  
22 and so on. We feel we have a method of distribution  
23 today in the wholesale house that provides this opportunity  
24 of buying many drugs on a bulk basis and supplying them  
25 in smaller quantities. In the past we have had experience  
26 in our own city of group buying in certain products but  
27 we found it not very satisfactory from many standpoints.

28 There was the problem that somebody had to supply a  
29 warehouse to keep it in, someone has to repackage and  
30 deliver it and there was the problem of collecting for  
it.

31 COMMISSIONER FIRESTONE: Collecting  
32 from the ----?





Turner 9563

MR. TURNER: From the individuals to whom it was delivered and it does not appear to have too much merit.

COMMISSIONER FIRESTONE: Was this a cooperative buying organization by participating drugstores or pharmacies?

MR. TURNER: That is right.

COMMISSIONER FIRESTONE: And it failed, I mean the attempt did not achieve the desired end?

MR. TURNER: It did not prove satisfactory at all.

COMMISSIONER FIRESTONE: And you feel it is difficult to develop such cooperative buying because of that?

MR. TURNER: Yes, and you also incur your cost of handling and warehousing and distribution amongst members...there is a certain cost.

COMMISSIONER FIRESTONE: Yes, a certain cost but presumably the economics would be such that your bulk buying would produce lower costs than your cost of handling, because if it did not, then bulk buying would make no sense. But would you not say if a group of pharmacists are negotiating with a drug supply house, they would be in a better bargaining position if they placed a large order than if each individual retail pharmacist negotiates directly?

MR. TURNER: I think possibly this has been taken care of in our wholesale distributing houses and I doubt if we bought all our pharmaceuticals on a bulk basis on a cooperative plan we would be setting







Turner 9564

up another wholesale distributing organization.

COMMISSIONER FIRESTONE: You feel this would not be desirable?

MR. TURNER: I do not think it is desirable, no.

COMMISSIONER FIRESTONE: May I turn to the following paragraph, Paragraph D on page 6 in which you refer to price reductions and say:

"Price reductions can be afforded, of course, through discount stores and mail-order operations."

Do these discount stores and mail-order operations employ pharmacists?

MR. TURNER: Oh, yes.

COMMISSIONER FIRESTONE: And how then, are they able to cut the price materially, to sell at a discount as compared with retail pharmacists' operations?

MR. TURNER: Most of the discount houses that I am familiar with, and I believe this is probably an average statement to make, in the first place, they have no telephone service; in the second place they have no delivery service; in the third place they have no pick-up service and in the fourth place they have no facilities for charge accounts. Now, it is the reasonable fact that without those services which are, in my opinion, very important to the people who require medication, particularly older people who are not able to go to specialized areas where there are discount houses and cannot get the advantage of delivery service and the services that are provided in the average community



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Turner 9565

pharmacy, they could well afford to possibly discount their finished product at probably a 50% or 20% rate. This can only be applied to those people who can go and take their prescriptions and wait for them and pay for them and take them home.

COMMISSIONER FIRESTONE: You point out that this is a serious competition from these stores and you would like to retain this business?

MR. TURNER: That is right.

COMMISSIONER FIRESTONE: Why could you not fight fire with fire and offer two types of service, one as the present service with the present price and the second is a service that you would say to the person, "If you will come to my pharmacy and pick up the drug and pay for it and take it home yourself, it would be 10% less"? You provide the same sort of drug and the same sort of service as your competition does, why can't you do that?

MR. TURNER: Well, you cannot do that on the volume of traffic that is enjoyed by a local independent pharmacist. On the other hand, I would think it very unprofessional and very undignified to say to one of my customers that if you come in and pick it up and pay for the medicine, I will give you a 15% discount, and on the other hand say to the other person who cannot afford to come and pay for it that he will have to pay 15% more. That would be, in my opinion, very undignified and I would not do it. In my particular business and I think probably a cross-section of the pharmacists of Ontario feel the same way, that the prices they are





thereby, they could well afford to possibly discount  
 their interest product at probably a 10% or 15% rate.  
 This can only be applied to those people who are going to  
 take their prescriptions and wait for them and pay for  
 them and take them home.

COMMUNITY DIVISION You point out  
 that this is a serious competition from these stores and  
 you would like to retain this business.  
 Mr. TULLIN What is your

you not fight with these and other two types of  
 service, one is the present service with the present  
 price and the second is a service that you would pay for  
 the person, "If you will come to my pharmacy and pick up  
 the drug and pay for it and take it home yourself, it  
 would be 50 cents? You provide the same sort of drug  
 and the same sort of service as your competitor on 100%  
 why can't you do that?

Mr. TULLIN Well, you cannot do this  
 on the volume of traffic that is enjoyed by a local  
 independent pharmacist. On the other hand, I would not  
 at any independent and very unqualified to say to  
 of my customers that if you come in and pick it up and  
 pay for the medicine, I will give you a 10% discount,  
 and on the other hand say to the other person who does  
 not come and pay for it that he will have to pay  
 the price. That would be, in my opinion, very unbusinesslike  
 and I would not do it. In my particular business I  
 think probably a cross-section of the population of  
 the city would be the same way, that the price is, and



Turner 9566

charging is taking care of a distinct pharmaceutical service to the patient.

COMMISSIONER FIRESTONE: Well, if there is a part of the public that does not wish to pay an extra 10% or 15% for such service, why are you then complaining if this public goes to outlets that provide them with the drugs without that service?

MR. TURNER: We are not complaining.

COMMISSIONER FIRESTONE: You are happy about the discount houses and the mail-orders?

MR. TURNER: We are simply stating that they made an inroad on the subscription business.

COMMISSIONER FIRESTONE: But you are not complaining about that at all?

MR. TURNER: Oh, no, we are not complaining.

COMMISSIONER FIRESTONE: May I now turn to the top paragraph of Page 7 where you say in the middle of that paragraph:

"...the pharmacists in answer to public demand entered into what is being called the drug sundries field and the bulk of the business of the retail pharmacy today consists of drug sundries."

Drug sundries, I take it, cover drugs that are not prescribed. Such miscellaneous things as cosmetics, soap, chocolates, soft drinks, etcetera?

COMMISSIONER McCUTCHEON: Magazines, books.

MR. TURNER: Yes.





Turner 9567

COMMISSIONER FIRESTONE: Do you feel that the time and professional training which the pharmacist has obtained is best used in selling cosmetics, cigarettes, chocolates, soft drinks and other sundries?

MR. TURNER: No, I do not think his time is best used in doing that, but it has become a fact that without the sundries in the drugstore in the past experience the pharmacy would not be able to finance a complete dispensary and man it with complete coverage of licensed pharmaceutical help.

COMMISSIONER FIRESTONE: If we only have a limited number of pharmacists and you are saying this is not easy to increase significantly that existing supply, there are always a few coming in, but that is not enough, would it not be in the interests of Canada and the people here in Ontario to make more effective use of the pharmacists you should have? What I have in mind particularly, would be the possibility of a system whereby the opening of drug dispensaries would be licensed by the Ontario Government whereby only licensed establishments would be permitted to operate as drug dispensers. This opportunity would be limited to people who are fully staffed with well-qualified pharmacists and there would be a sufficient number to service the Province adequately and also allow a sufficient volume of business to pursue the operations of these drug dispensers profitably. Now, that would avoid for a qualified pharmacist having to sell cosmetics, soap, etcetera. Would you be in favour of such a system?

MR. TURNER: Well, in the first place,







Turner

9568

I do not think you would provide under that system the convenient availability to pharmaceutical services in any particular community. Secondly, I might say that I am very happy that we operate under a free enterprise system and I think this would certainly not be in the interests of free enterprise to not allow a man to operate a business where he so chose. I do think that the matter of convenience is important. Not only is a pharmacy in a community a valuable asset to the community, he offers many services during the day from which he get no remuneration and which are valuable to the public.

COMMISSIONER FIRESTONE: I accept that, in fact, my questioning is based on the premise we would like to make more effective use of the many good qualities which the pharmacist has, we would like him to be a pharmacist all day instead of part of the day. What is your objection to that principle?

MR. TURNER: I do not object to the principle, but I think the principle will probably be applied through an evolution in a matter of years, but I also believe in the free enterprise system whereby a man may open a business where he chooses.





/FF/ss

Turner

9569

COMMISSIONER FIRESTONE: You refer in this paragraph to the public concern that exists in Canada as to drug prices and costs. I take it this public concern to which you refer is to the fact that people claim drug prices and drug costs in Canada are too high?

MR. TURNER: Yes.

COMMISSIONER FIRESTONE: You further say in this paragraph we do not feel that any of the suggestions which have been proposed to resolve the problem of prices are satisfactory and practical. Have you any suggestions?

MR. TURNER: Well, I believe that our interest as an Association in the operation of the Green Shield Plan and from what we have been able to find out, we believe there is a possibility in this plan to make drugs available to the public on a budgeted basis where the sudden impact of sickness wouldn't be of such prime concern as it is today. I think this question will probably be answered in the brief of the Green Shield. I would like to refer you to that brief.

COMMISSIONER FIRESTONE: Then, I gather that one constructive positive proposal which you are making is that by adopting Green Shield, perhaps extending it --- you were talking about the group that isn't covered?

MR. TURNER: Yes.

COMMISSIONER FIRESTONE: This objective would be attained.

MR. TURNER: This objective would be attained.







Turner 9570

COMMISSIONER FIRESTONE: I  
pursue the question further on that point after we have  
heard from the Green Shield. Thank you very much.

COMMISSIONER BALTZAN: There is one  
statement here that doesn't seem to sit right with me.  
I will read it to you. It is on page 4 at the bottom:  
"We submit that it is true that the reduction of the cost  
of drugs will cause an increase in the utilization of  
drugs by the public, which we believe to be in the public  
interest."

MR. TURNER: Yes.

COMMISSIONER BALTZAN: Is it the idea  
of the medical profession and your profession to make  
available drugs so people can have more drugs?

MR. TURNER: No. As a result of the  
studies of the Green Shield that have come to our atten-  
tion, the fact is that many people have drugs prescribed  
for them by the physician who are unable to get the  
prescription filled, because they can't afford to get it  
filled, it may be a costly drug. We submit that by  
budgeting or lowering the cost of drugs, the drugs the  
people need would be used. It isn't that they would use  
more drugs, but they would use the drugs that they need.

COMMISSIONER BALTZAN: That is exactly  
the answer I wanted to take out of this rather than it  
would make it possible to increase the consumption of  
drugs.

MR. TURNER: They wouldn't be taking  
more drugs per se. They would be taking drugs they needed  
that they weren't now getting for themselves.





Turner 9571

COMMISSIONER BALTZAN: That is all,  
thank you.

THE CHAIRMAN: Thank you, Mr. Turner.  
I take it now, Mr. Wilkinson, you will deal immediately  
with the second brief which is Exhibit 259.

MR. WILKINSON: Mr. Chairman and members  
of the Commission, I will read the summary and conclusions  
of the Prescription Services Inc. brief:

A SUBMISSION TO THE ROYAL COMMISSION  
ON HEALTH SERVICES BY PRESCRIPTION  
SERVICES INC. OF WINDSOR, ONTARIO, A  
NON-PROFIT CORPORATION OFFERING A  
VOLUNTARY PREPAID PRESCRIPTION PLAN  
COMMONLY KNOWN AS "THE GREEN SHIELD  
PRESCRIPTION PLAN" (a trade marked name)

DIVISION A - SUMMARY AND MAIN CONCLUSIONS

1. The purpose of Prescription Services  
Inc. (hereinafter sometimes referred to as "Green Shield")  
lies in the development of a feasible solution of the  
problems that have concerned the public at large and that  
have now become the concern of this Commission so that the  
compounding and dispensing of drugs may be made widely  
available in circumstances ensuring methods of safety and  
skilled professional assistance while maintaining reason-  
able cost levels.

2. Much has been said in the past before  
Commissions and investigations of many types and nature  
and much will be said before this Commission about the  
special problems affecting that part of the provision of  
health services which lies within the field of the







Wilkinson 9572

dispensing and compounding of prescription drugs. Some, if not all of these problems are outlined herein for the purpose of touching upon them and for the purpose as well of showing how the Green Shield plan provides a feasible answer to these problems. Additionally, it is worth noting that for all the Commissions and investigations that have taken place in this Country and in the United States of America with a view to determining whether or not the retail prices of drugs are excessively high and for all the public concern which gave rise to these investigations and Commissions no organization has brought forward a plan specifically related to prescription drugs which will resolve these matters in the public interest while securing broad availability of drugs at reasonable cost levels other than the Green Shield plan which is the first of its kind in the field of prescription drugs and is unique in its conception in this field throughout the world.

3. The causes of concern which gave rise to the Green Shield plan and its consideration by certain members of the Essex County Pharmacy Association of Essex County, Ontario as far back as 1953 are outlined in some detail in our written submissions, but briefly they are as follows:

(a) The past 25 years has seen an enormous development in the improvement of techniques of health services and the extension of research in the field of prescription drugs - so much so that in many instances where in the past extended illness, hospitalization, surgery and physical impairment would have taken place,





Wilkinson 9573

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3 today with the advent and extension of prescription  
4 drugs these same health problems may be cured by the  
5 simple administration of drugs over a relatively short  
6 period of time. This has resulted in a substantial lower-  
7 ing of the cost of the curative methods of health, but  
8 at the same time there has arisen the problem that many  
9 of the newer drugs (particularly in the antibiotic field)  
10 which are so successful in fighting disease fall in the  
11 higher bracket of drug costs and in many instances, well  
12 above the average cost of a prescription drug. It has  
13 been recently stated that the national average cost of  
14 prescription drugs is about \$3.06; the national average  
15 cost, therefore, is reasonably well absorbed by the  
16 average pocketbook, but where the drugs prescribed fall  
17 in the higher bracket of drug prices the average pocket-  
18 book finds it more difficult to pay for the drugs. There  
19 is, in addition, what is known as the catastrophic  
20 impact of drug costs, that is to say, the extended use of  
21 drugs upon a repeat basis over a period of time. While  
22 the use of drugs averaged over any extended period of time  
23 may not be high per unit, nevertheless when taken and  
24 purchased upon a repeat basis over a comparatively short  
25 period of time without adequate financial reserves against  
26 the impact the result may well be a great burden financially.

27 (4) For the foregoing reasons the matter  
28 of drug costs was reviewed with concern by the creators  
29 of the plan and this is, of course, a matter that has been  
30 of concern to the public and is of concern to this  
Commission. Suggestions have been put forward in the  
matter of drug costs, as for instance, the proposals







Wilkinson 9574

for bulk purchasing of drugs at the retail or other level as well as the proposals that physicians should prescribe through the use of generic rather than brand names of drugs. The opinion of the incorporators of the plan was (and still is) that bulk purchasing of drugs is not feasible at the level of the retail pharmacist (whose pharmacy is, after all, the centre of prescription drugs); in addition, so far as generic names were concerned, there were problems of quality control, physician education, including the reluctance by physicians to use such method, potency of drugs and the lengthy and confusing names that arise out of the use of generic names for drugs. These proposals then did not appear to be practical ones for the price reductions in drugs.

(b) Pharmacy has always been regarded as a profession and its practitioners as skilled professional people requiring extensive training and education in theory and in practice. It seems unquestioned that anyone would seriously suggest that the compounding and dispensing of prescription drugs should be done by any person less well trained than a pharmacist, unless, of course, it is by a physician dispensing drugs which he himself prescribes, the physician in this case being an equally skilled professional. The great extension of research in prescription drugs has accentuated the necessity for the pharmacist in the compounding and dispensing of prescription drugs simply in the interests of ensuring safety to the public. The consequence is that there is an ever increasing need for ensuring extensive training and education in the field of pharmacy, but the





Wilkinson 9575

number of persons graduating from the profession continues to decrease. However, pharmacy, at the time of creation of the Green Shield Plan and today is faced in its retail level special problems which had a very direct effect on its capacity to maintain a proper professional level in the interests of public safety and convenience. Some of these problems are -

(i) The individual retail pharmacy is for the most part a combination of the professional compounding and dispensing of prescription drugs and the sale of non-prescription drug items including general merchandise. There exists therefore the necessity of ensuring that the professional aspect is sustained at a level (particularly in the public interest for obvious reasons of safety) in spite of the necessity as well of carrying on a regular merchandising operation in non-drug items;

(ii) The low average gross profit of the retail pharmacy carried through all its operations against its high cost of drug expenses in terms of skilled expensive professional help;

(iii) The newer problems of the discount store, the cut-rate store, the mail order drug operation and the public concern about drug prices.

(5) It becomes more difficult daily to ensure a continuing development of skilled professional people who will be available to compound and dispense prescription drugs to







Wilkinson 9576

the public in the future and thus to ensure to the public the safety which it is entitled to expect in the matter of this important arm of health services. Put in another way, notwithstanding public concern about drug prices the individual pharmacist is having considerable difficulty in maintaining any reasonable profit level in terms of his own business having regard to the high costs of professional help; but without this professional help the public can not be sure that it is being properly served in a matter so vital to it as the provision of health service which may have life or death or personal injury implications.

(6) The creators of the plan attempted to strike at the root of the problem, which is the development of a plan which would permit the wider availability of drugs by the public at reasonable cost levels. In considering any such plan the incorporators were of the view that there were two underlying considerations, namely:

(a) That the freedom of the individual member of the public should be protected in that he -

(i) Would be free to determine whether he wished to enjoy the benefits of any proposed plan;

(ii) Would be free to select a plan which he considered to be desirable;

(iii) Would be free to determine the extent of the coverage which he felt was desirable.

(iv) Would be free to purchase his drugs from the pharmacist of his own choice and in whom he reposed his confidence.





Wilkinson 9577

(b) The provision of the plan upon a non-governmental level or basis was desirable for two reasons:

(i) It was felt that it had been generally the philosophy of government for many years past in this Country that if a need may well be provided upon a private or non-governmental basis then subject to any regulation that might be proper in the public interest a private or non-governmental plan should be encouraged and the governmental plan only implemented when the need could not be adequately fulfilled upon the private basis;

(ii) The tendency of similar plans, particularly in the health field, which are operated on a governmental level is to provide for the payment of part of the cost of operation through taxation so that, in fact, the extension of the services provided for by the plan are not being fully paid for by premiums thereby tending to hide its actual cost. Governmental plans tend to become more expensive without the public becoming aware of the fact of such expense and additionally, we are of the opinion that governmental plans are more costly in their administrative procedures than a private plan in which the public is aware of the direct relationship between the extension of the services and the premium cost thereof.







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(7) The plan that was developed is known as the Green Shield Prescription Plan. The Green Shield Plan is a voluntary prepaid plan whereby Prescription Services Inc., which is a non-profit corporation incorporated under Ontario law acts as a fiscal agent on behalf of subscribers drawn from the public and on behalf of pharmacies that have become members of the corporation. Prescription Services Inc. enters into agreements with individual pharmacies or pharmaceutical corporations compounding or dispensing drugs at the retail level to the public. Prescription Services Inc. agrees to reimburse the member pharmacy for drugs compounded or dispensed by the member pharmacy to subscribers and their dependents upon a schedule of prices as predetermined by the corporation, subject to a deduction therefrom of 10% of the allowed price of prescriptions for administration costs and for further deduction in the event of the plan operating at less than cost. Prescription Services Inc. also offers to the subscriber upon a group insurance basis without medical requirements the right upon the payment of the premiums fixed by the Corporation to have prescriptions issued by a lawfully qualified medical practitioner or dentist to the subscriber or his dependents dispensed by a member pharmacy of their choice without cost to the subscriber, except for the aforesaid premium payment and a fixed 35¢ charge payable in respect of each such prescription dispensed made directly to the pharmacy dispensing the prescription. The exact mechanics of the plan are set out in the brief, which has been filed with the Commission.





MP/hm

Wilkinson

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(8) When taking up our initial studies in 1953 we were interested to discover that there were not available any statistical surveys on this Continent in this field of health services which would correctly detail the utilization factor for prescription drugs provided in a prepayment plan, particularly as divided between various classifications of age, sex, geographical location and other relevant information. Naturally, the utilization factor would have a determinant effect on cost. As a consequence, we were required to create our initial premium rates by estimation based upon the only source of Canadian information available which was the Canadian Sickness Survey in 1951-1952. That survey indicated that the average number of prescriptions purchased by Canadians in those years was 2.3 per year with a cost of such 2.3 prescriptions being \$4.32 in the aggregate, or approximately 36¢ per person per month. At the inception of the plan in 1957 the cost of living factor was 119% of the cost of living factor in the years 1951 to 1952 so that the 36¢ per person per month cost was multiplied by such factor to produce a figure on a comparable basis for the year of inception of 42¢ per person per month; it was felt, however, that this factor did not give effect to any increase that might arise as a result of the economic barrier in respect of dispensing prescriptions being removed and in order to provide adequate protection for such an increase the 42¢ monthly figure was doubled to give an average premium rate of 85¢ per person per month. Reference was made to data through Windsor Medical Services Inc.,







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3 a prepaid medical plan operating in the Windsor area from  
4 which it appeared that the average family size in the  
5 plan was two adults and 1/2 of one child and upon the  
6 basis of this data a rate structure was set which it  
7 was hoped would return the plan the average of 85¢ per  
8 person per month being the figure required to enable  
9 the plan to be self-sustaining. It was felt that a  
10 premium structure, which made it less expensive for  
11 children under the plan, would make it more attractive  
12 for the public so that instead of charging a flat rate  
13 of 85¢ per person per month a system of staggered  
rates was established as follows:

14	Adult subscriber	-	95¢
15	Spouse	-	95¢
16	Adult dependent	-	95¢
17	First Child	-	65¢
18	Second Child	-	55¢
19	Third Child	-	45¢
20	All Additional Children	-	Free

21 (9) It became readily apparent after a  
22 few months that the estimate of premium rates contained  
23 a wide error. There were a number of reasons for this,  
24 which are detailed elsewhere in our submission, but in  
25 brief, the answer appears to be that none of the surveys  
26 that had been made took into account the increase in  
27 utilization when the cost of drugs, through the  
28 averaging effect of a month premium method, is reduced,  
29 nor do they take into account the fact that age and  
30 sex together serve to differentiate persons with respect





Wilkinson

9581

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4 to utilization of drugs more than any other character-  
5 istics.

6 (10) We were fortunate in being able to  
7 establish a relationship with the School of Public  
8 Health, Bureau of Public Health Economics of the  
9 University of Michigan at Ann Arbor, Michigan, so that  
10 extended statistical studies were made of the  
11 Green Shield Plan and the results made available to us.  
12 As you know, these studies in their various forms have  
13 been made available to the Commission upon a confidential  
14 basis.

15 (11) As a consequence of our early studies  
16 it became apparent to us that it would be necessary to  
17 adjust the rates upward to obtain an average premium  
18 of \$1.54 per person per month. However, the greatest  
19 number of persons under the plan were adults (the  
20 average size of the families under the plan then being  
21 2.7 persons) and as the adults gave rise to the  
22 greatest utilization it was felt necessary to provide  
23 a combination of rates which would raise the premiums  
24 substantially in the adult class, but raise the premiums  
25 for the children only slightly. The rate structure  
26 was consequently varied in 1959 and the combination  
27 chosen was one that would yield an average premium  
28 per person per month of \$1.56, the directors of the plan  
29 erring on the side of caution in respect of the average  
30 premium to be obtained to the extent of 2¢. As a  
consequence, the premium structure was changed to its  
present form which is as follows:







Wilkinson

9582

Adult Subscriber - \$1.90

Spouse - \$1.90

Adult dependent - \$1.90

The first 3 children - \$ .65

Children after the first 3 - Free

(12) The experience of the plan as shown in the statistics which are now available indicate that the average premium per person per month of \$1.56 is not quite being achieved. This is largely, however, because of a decision made by our directors to maintain the plan in its pilot plan formative stage until such time as adequate studies had been completed to permit us to actively negotiate for the increase of the groups and individuals under the plan. We are satisfied that as the number of persons insured under the plan increases this average premium cost per person per month will be achieved and we expect as well that substantial enlargement of subscribers under the plan will result in a rate reduction, particularly as the plan is introduced as a result of labour management negotiation contracts where, for simple administration reasons, 100% of all persons in a labour bargaining unit will be introduced as subscribers, thereby ensuring a broad range of healthy persons as well as a broad range of persons who have a greater and more active need of prescription drugs.

(13) We have also given consideration to whether or not our plan and the studies which we have made may properly be extrapolated from the demographic



UNITED STATES OF AMERICA

DEPARTMENT OF JUSTICE

CRIMINAL DIVISION

WASHINGTON, D.C. 20535

TO: THE ATTORNEY GENERAL

FROM: THE ATTORNEY GENERAL

SUBJECT: [Illegible]

DATE: [Illegible]

RE: [Illegible]

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4 composition of the Green Shield plan to the demographic  
5 composition of a larger area, particularly the whole  
6 of Ontario. While, for the reasons pointed out in our  
7 brief, the statistical material which we have obtained  
8 provide proximates, nevertheless there is a sufficient  
9 comparison between the studies of the Green Shield groups  
10 compared with the general Windsor metropolitan area as  
11 to permit us to feel that our studies may be reasonably  
12 extrapolated into the demographic composition of the  
13 Windsor metropolitan area; furthermore, (and particularly  
14 because urban areas require greater drug utilization  
15 than non-urban areas) we are of the opinion that if  
16 these results may reasonably be extrapolated into the  
17 demographic composition of the Windsor metropolitan  
18 area they may reasonably be extrapolated into the  
19 demographic composition of the whole of Ontario, or any  
20 large area that is selected which provides the necessary  
21 level of population. We are of the opinion that in its  
22 form as it now stands the Green Shield plan can be  
23 extended, both in numbers of persons enrolled and in  
24 coverage of benefits so as to cover all persons in  
25 Ontario, or for that matter Canada, or any special  
26 areas selected, so long as the plan is operated in  
27 sufficiently large group or groups; that is to say, if  
28 the area selected were Ontario and the plan was  
29 extended in sufficient numbers, then all of the persons  
30 involved in the plan, whether enrolled as individuals,  
or in small groups could be treated as one large group  
for the purpose of putting the corporation upon a  
self-sustaining basis. To ensure that the plan may be







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4 extended throughout Ontario so that all persons enrolled  
5 would have the benefit of the group aspect of the plan  
6 we have divided the Province into 15 divisions upon the  
7 basis of population and retail pharmacy concentration  
8 and we are of the opinion that this division coupled  
9 with the present premium rate structure now in force  
10 would permit the enlargement of the plan upon a self-  
11 sustaining basis. We would also say that by reason  
12 of our existing International Business Machines card  
13 system and the breakdown of the Province into the  
14 15 divisions in question it is entirely feasible for  
15 us to administer all of the divisions from our present  
16 headquarters at Windsor.

17 (14) So far as extending the plan beyond  
18 the Province of Ontario we would say that we have no  
19 present intention to do so; however, we see no reason  
20 why similar non-profit corporations organized in other  
21 Provinces of Canada can not be incorporated for the  
22 purpose of providing a voluntary prepaid prescription  
23 plan organized upon the same lines as the Green Shield.  
24 To this end we are quite prepared to facilitate any  
25 proper non-profit corporation organized for such purpose  
26 and to make available to it all of our studies and  
27 the basis of our plan upon the payment of a nominal  
28 single licensing fee to recover the costs of our  
29 studies in the pilot plan and such licensing fee will  
30 also include the right to use the trade mark "Green  
Shield Prescription plan".

(15) In conclusion we submit that the Green  
Shield Prescription Plan provides an answer to the  
problems that concern this Commission and the public





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4 at large as well as the pharmaceutical profession in  
5 that field of health services involved in the compounding  
6 and dispensing of drugs both in the greater availability  
7 of drugs and the offering of the same at reasonable  
8 cost levels.

9 (16) There are, of course, benefits that will  
10 accrue to the profession of pharmacy. The implementation  
11 of the Green Shield plan will maintain the retail  
12 pharmacy in its traditional position as the centre for  
13 distribution of prescription drugs in a safe, professional  
14 and convenient manner. At the same time the pharmacist  
15 will be able to resolve the economic problems that face  
16 him so that he can continue to maintain the practise  
17 of his professional level.

18 (17) Whatever the benefits, however, that  
19 may accrue to the profession of pharmacy the important  
20 consideration must always be the public interest. The  
21 single factor of importance for the public is that there  
22 be wide availability of prescription drugs, that is to  
23 say, if there is a need for the use of a prescription  
24 drug by the public that such prescription drug can be  
25 made available to the public when the need arises. Cost  
26 of drugs is a consideration which becomes important when  
27 the costs of prescription drugs rise above the ability  
28 of the average pocketbook to pay for the drugs putting  
29 the public in the position where the drugs, although  
30 available, can not be used for lack of funds to pay for  
them. We are satisfied from our studies that there is  
a direct relationship between utilization of prescription  
drugs and costs in that when the cost factor is eliminated  
as a matter of concern the utilization increases; a plan,







Wilkinson

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3 therefore, that eliminates cost factor and places  
4 primary importance upon the greater availability of drugs  
5 is a plan that naturally will best serve the public  
6 interest. The Green Shield plan is just such a plan  
7 since by the premium system of budgeting full utilization  
8 by the public of its benefits is permitted and such,  
9 in fact, has been the result of the operation of the  
10 plan and can be established statistically. The monthly  
11 budgeting or averaging system of premium payments  
12 has served to eliminate cost as a matter of concern to  
13 the public and in particular has eliminated the  
14 catastrophic impact of drug costs when drugs are required  
to be taken upon a repeat basis over a period of time.

15 (18) We submit that the Green Shield Plan  
16 is a soundly based well analyzed plan unique in its  
17 concept and development which will permit the public  
18 to enjoy its services and the greater availability  
19 of prescription drugs while at the same time providing  
20 a solution to the problems that face the pharmacist today  
in the field of prescribed pharmaceuticals.

21 Respectfully submitted, sir.

22 THE CHAIRMAN: Thank you very much  
23 Mr. Wilkinson. You have done here what we might well  
24 have had to hire a scholar to do. That is, to give us  
25 from your practical experience in Windsor the figures  
26 upon which we go forward to find what the total  
27 prescription drug bill for Canada is for a given year  
28 and on the basis of the \$1.56 a month you get \$18.72  
29 a year per person. With 18 million plus persons you  
come up with a drug bill in excess of \$300 million a year.





Wilkinson

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Now is that pretty well the conclusion that you people have come to?

MR. WILKINSON: I haven't multiplied it out sir. We did in our brief, and I was just trying to put my hand on it here. In round figures, on page 47, we have applied these two premiums, one of \$1.49, the other \$2.54 which we have calculated for each 200,000 of population will be \$312,490.00 a month.

THE CHAIRMAN: You are probably aware this is a figure that is substantially higher than that which has been published by the Department of Public Health and Welfare, or even by the Dominion Bureau of Statistics as prescription drug costs for Canada. Have you any reason to believe that your utilization rate in Windsor will be higher than an average place in Canada?

MR. WILKINSON: No sir, there is no reason to believe that this will be.

THE CHAIRMAN: Does it arise from this fact: There is a suggestion that Windsor is a higher income area, high in the relative sense, speaking of Canada as a whole.

MR. WILKINSON: I do not believe sir that you can count on a lesser figure with possibly one exception. Windsor has Ontario Hospitalization almost universal, and has the Windsor Medical Services almost universal. Therefore, cost as a barrier to either seeing the doctor or going to the hospital has been removed.

There could possibly be then a greater utilization as a result of freer access to the physician's office.







Wilkinson

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4 However, if we are anticipating the  
5 extension of voluntary physicians' plans across the  
6 nation, we must take this into consideration in every  
7 other urban community. There is also the fact that  
8 a good deal of Canada is rural and there are no pharma-  
9 cies and there, perhaps, is not the availability of the  
10 patient to get to a pharmacy. In these areas there may  
11 be a lesser utilization but on balance I would say that  
12 to calculate a lesser figure than this would be at your  
13 own peril.

14 THE CHAIRMAN: What is the percentage  
15 of population you cover? I think you give this here  
16 but what is it in fact - Green Shield?

17 MR. WILKINSON: Our pilot plan at the  
18 moment is running at 1,500 subscribers.

19 THE CHAIRMAN: And you found that the  
20 utilization rate has increased threefold; is that the  
21 figure you have here, as soon as the urban - page 38:

22 "As soon as the urban residents  
23 became members the number of prescrip-  
24 tions per person per year approximately  
25 tripled."

26 MR. WILKINSON: I would like to qualify  
27 that; that is approximate when you come to the actual  
28 utilization on page 41, the bottom of the page, the  
29 number of prescriptions per person, a month of coverage,  
30 under the regular group it is .37 and if you multiply  
this by 12 you would have the number of prescriptions  
per year.

In the retirees, the special group





Wilkinson

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being run as a research group, the factor is .6. You can see from these two figures that people over 65 use almost double the number of prescriptions per person per month.

Now, prescriptions per person per month only become meaningful when you relate it to the average cost of the prescription in the age bracket and here again you find a variation. You find the average cost of a prescription according to our schedule of fees on page 42 for the regular group, which includes all ages, is \$4.05 and for the retirees it is \$4.25.

THE CHAIRMAN: Even though they have twice as many prescriptions?

MR. WILKINSON: Yes, sir.

THE CHAIRMAN: As I say, this study - your experience is something that is going to interest our research people tremendously because it is the only actual program of its kind in operation in Canada. It varies so much from the figures that have otherwise been accepted in the amounts spent in Canada on prescription drugs which the Dominion Bureau of Statistics has taken out of the returns that go to them.

There is a drug co-operative in the Northwestern United States in the Seattle-Tacoma area; are you familiar with what their experience is per person per year?

MR. WILKINSON: Are you speaking of the Kaiser group in Seattle, Washington?

THE CHAIRMAN: No, it is a drug ---

MR. WILKINSON: I was not aware there







Wilkinson

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4 was one. There are two others, one in operation and  
5 the other is not off the ground yet but there was one  
6 modelled after ours, although there are differences, in  
7 California.

8 THE CHAIRMAN: This one appeared and  
9 gave a submission before Senator Kefauver's Committee  
10 and that is where I got the copy of it, from the  
11 Kefauver Committee. I have not got this with me and  
12 cannot make a comparison on the same type of operation.  
13 I think theirs is a co-operative, a consumer co-operative  
14 as distinct from a supplier co-operative, but that would  
15 be the only difference.

16 COMMISSIONER FIRESTONE: Mr. Wilkinson,  
17 we may turn to page 2 on the top paragraph and I under-  
18 stand you are making the point that the Green Shield  
19 plan is a plan which aims at "securing broad availability  
20 of drugs at reasonable cost levels". Could you define  
21 to us what you mean by "reasonable cost levels"?

22 MR. WILKINSON: We mean a constant  
23 budgetary figure in the form of a premium on a monthly  
24 basis that is within the reach of the pocketbook of the  
25 average working man.

26 COMMISSIONER FIRESTONE: What happens  
27 to people whose income is below that of the average  
28 working man or, in the second case, where people have the  
29 income of the average working man and then become  
30 unemployed?

MR. WILKINSON: I would gather that you  
mean that we have two groups of people; we have the  
people for whom the Government has already accepted



was one. There are two others, one in the north and  
the other in the south. The first one was the  
first of the three, and the second one was the

second of the three. The third one was the  
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Wilkinson

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responsibility to take care of some of their basic requirements and then we have another group of people who have illness strike and might become a charge of the Government.

COMMISSIONER FIRESTONE: I do not know whether they would become a charge of the Government, they would just be unable to pay for such services because of unemployment or whatever reason there may be.

My question is; perhaps you could break it into two parts: is your suggestion, in extending the benefits of the Green Shield plan to all the people of Ontario or making it available to all the people of Ontario, that if you made available to all those who can pay the premium to pay this premium that you have considered reasonable and those that cannot afford to pay the premium should have their premium paid by the State; is that the plan you envisage?

MR. WILKINSON: Yes, that is what we envisage.

COMMISSIONER FIRESTONE: Would you then envisage ---

THE CHAIRMAN: Would you excuse me? Do you envisage that or that the State will continue to pay for the prescriptions of those in receipt of social aid which, as I understand it, they do now?

MR. WILKINSON: We would suggest that the Government, and I am speaking now of the Provincial Government, would enter into an arrangement with the Green Shield plan to pay the premium for the people for whom they feel they have responsibility and for any







Wilkinson

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people for whom they feel they have a further or future responsibility whether it be through additional members joining the welfare roles or otherwise. In this way we envisage the Provincial Government being relieved of any administrative problems in the supplying of drugs through all of the many different forms of contracts which they now presently have with all the various municipalities and let us, through premium payment, assume the responsibility of payment of the pharmacists for this service.

COMMISSIONER FIRESTONE: And presumably there are other reasons as well. You mention one sensible reason and that is, let the organization which is the most knowledgeable on the subject administer the plan and relieve the Government of the administrative headaches and administration; that is one you mention?

MR. WILKINSON: Yes, sir.

COMMISSIONER FIRESTONE: Would you say there would be other reasons, that such a plan centrally administered by the Green Shield organization would be a more efficient plan because the coverage would extend to all the people of Ontario or all those that are covered and by having a larger number of persons covered there would be spreading the risk among a larger number of people and that might enable you to operate the plan more economically. Am I right in this implication?

MR. WILKINSON: If I understand your question correctly, you are projecting a very large number of people into this plan?

COMMISSIONER FIRESTONE: If I might





Wilkinson

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4 explain, I am following your own suggestion that you  
5 feel this could be extended to cover or may be made  
6 available to cover all the people of the Province of  
7 Ontario, including the indigent and medically indigent,  
8 for which the Government may be paying the premium.  
9 If this is the case, would, in your opinion, the plan  
10 operate more efficiently than if it is cut up in certain  
11 segments?

12 MR. WILKINSON: I have never given the  
13 idea of having branch offices which is probably what you  
14 are suggesting; I have never given this any thought.  
15 At the moment, as far as we have thought this thing out,  
16 we think we can handle a tremendously increased number  
17 without any problem.

18 COMMISSIONER FIRESTONE: Well, Mr.  
19 Wilkinson, it is really my shortcoming in not putting  
20 the question more clearly to you. I accept what you have  
21 said. It is most efficiently administered from a  
22 central point. My question is: if you have a larger  
23 number of people covered by the plan rather than a  
24 smaller number, would the spreading of the risk over a  
25 larger number of people be a more efficient system than  
26 spreading it over a smaller number of people?  
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Walker

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4 MR. WALKER: I don't think Mr. Wilkinson  
5 nor do I think the brief says it would be most efficiently  
6 operated from a central system. I think all that was  
7 said in the brief was that we envisage it would be  
8 possible to operate that way. That is not saying it  
9 could only be a single plan or because it was a single  
10 plan it would be more efficient.

11 COMMISSIONER FIRESTONE: I would be  
12 very happy to come back to this central administration  
13 point. We were talking about coverage in terms of the  
14 number, I believe. Would you say the larger number of  
15 people covered would enable you to operate more effi-  
16 ciently than a smaller number?

17 MR. WILKINSON: We don't know. Certainly  
18 a larger number than we have now would be very welcome.  
19 We may reach a point where it becomes diminishing  
20 returns. We have no idea at the moment. It may just  
21 be possible that it happens.

22 COMMISSIONER FIRESTONE: Fine, we will  
23 accept that, Mr. Wilkinson.

24 COMMISSIONER McCUTCHEON: You might  
25 even reach the point of no return.

26 COMMISSIONER FIRESTONE: Could you  
27 perhaps comment on the point that was just raised as  
28 to the administration from a central point? Could you  
29 elaborate this in your own words as to the effectiveness  
30 and administration of such a plan from a central point  
for the people of Ontario, using your own words?

MR. WILKINSON: What I intended convey  
was that because of the foresight of the founders of this





Wilkinson

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3 plan in going directly to I.B.M. methods that we believe  
4 this system to be capable of very rapid expansion. I  
5 think we could handle perhaps most of Ontario, if not  
6 all of Ontario from our office in Windsor.

7 COMMISSIONER FIRESTONE: Would you say  
8 that such an operation, in your judgment, based on the  
9 experience you have had with the pilot study, would be  
10 an efficient operation?

11 MR. WILKINSON: I believe so.

12 COMMISSIONER FIRESTONE: Thank you.  
13 May I now turn to paragraph 7 on page 7?

14 THE CHAIRMAN: Before we leave that  
15 matter, you say if you were looking at this on the  
16 basis that the Government would pay the premium for  
17 those who are of necessity unable to pay, have you  
18 in mind the same premium as for those who are self-  
19 supporting, or a different premium?

20 MR. WILKINSON: I can't answer that.

21 THE CHAIRMAN: All right.

22 MR. WILKINSON: At the moment, we are  
23 trying to develop a plan that we can discuss with some  
24 of the Deputy Ministers and I just can't answer the  
25 question at the moment.

26 THE CHAIRMAN: If your thinking hasn't  
27 gone that far we cannot complain. You have gone a long  
28 way further than anybody else. Now, are you in a posi-  
29 tion to tell us what the average cost per person for  
30 prescription drugs is amongst those receiving social aid  
by the Province? If not, we will get it from the Depart-  
ment of Welfare.







Wilkinson

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MR. WILKINSON: No, I can't. I did have a series of those figures about two years ago, but from memory I certainly couldn't even give you the two year-old data.

COMMISSIONER FIRESTONE: If we may now turn to paragraph 7 on page 7, sir, referring to the middle of the paragraph to a schedule of prices as predetermined by the corporation. Then there are certain deductions from the schedule of prices. Is this schedule of prices the same as the schedule of prices which the retail pharmacists use in selling drugs to the consumer directly?

MR. WILKINSON: Yes, sir.

COMMISSIONER FIRESTONE: Thank you. I now come to this point, if I may, Mr. Wilkinson, that I asked Mr. Turner earlier and we deferred until we had the opportunity to get your advice. We appreciate your advice. You have done a first-class job in telling what is practical and feasible.

I would like to visualize how such a plan would work. You may recall I quoted a sentence from the submission of the Ontario Retail Pharmacists in paragraph 30, page 39, and I quote again with your indulgence:

"We do not feel that any of the suggestions which have been proposed to resolve the problem of price are satisfactory and practical."

I understand that the suggestion was if the Green Shield plan were adopted it would be a





Wilkinson

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3 contribution resolving and I quote "the problem of price"  
4 and the reference here is to drug costs which some  
5 people claim are high. Can you explain to us how the  
6 adoption of the Green Shield plan would resolve what  
7 some people claim is a problem of high cost drugs?

8 MR. WILKINSON: Commissioner Firestone,  
9 we do not believe that the cost of a prescription is  
10 high. It may be true I am entering here into semantics  
11 but I think this should be made clear. The cost of  
12 continued medication, the catastrophic impact of  
13 continued medication, is a great burden on many families  
14 and their method of expressing this is to say that the  
15 cost of drugs is high.

16 If a system could be devised whereby  
17 the peaks and valleys of medication costs are taken  
18 out, where the public is no longer concerned with the  
19 unit cost of any individual prescription, but only  
20 concerned with the annual cost, and that this is made  
21 available on a budgetary system by prepayment, then  
22 these people will not longer express their dismay in  
23 the words "Cost of drugs is too high."

24 Prepayment, in our judgment, does this  
25 because if the person who joins the plan who is well is,  
26 in fact, paying his premiums against the day when he  
27 most assuredly will be ill. The person who joins the  
28 plan and becomes sick very quickly, having paid one or  
29 two premiums, will continue to pay in the plan and so  
30 there is a post-payment here. The whole thing then is  
averaged out and the individual cost of any prescription  
does not become a matter of concern. To this extent we







Wilkinson

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believe that you will have found a satisfactory and practical solution to what is erroneously called the high cost of drugs.

COMMISSIONER FIRESTONE: I take it, then, sir, if I understand you correctly, the Green Shield plan will not contribute to the reduction of unit costs, but will, through this system of prepayment, even out the payments made by individuals covered by the plan? Is that the essence of your plan?

MR. WILKINSON: That is true.

COMMISSIONER FIRESTONE: Thank you very much. You have been very helpful.

THE CHAIRMAN: Commissioner Baltzan?

COMMISSIONER BALTZAN: Just one question, Mr. Chairman. Mr. Wilkinson, how is your corporation resolving the complaint we heard not so very long ago; the competition on the part of the discount houses and the cut-rate stores?

MR. WILKINSON: It is of no concern to the administrators of the Green Shield plan where the patient receives his or her prescription, provided that the prescription is filled, dispensed in a pharmacy by a pharmacist duly licensed and registered in the Ontario College of Pharmacy.

The patient pays the same 35¢ regardless. We reimburse the pharmacist whether he be a discounteer, a cut-rater or the largest prescription pharmacy in town.

COMMISSIONER McCUTCHEON: But the subscriber must deal with a member pharmacy?





ANGUS, STONEHOUSE & CO. LTD.  
TORONTO, ONTARIO

Wilkinson

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MR. WILKINSON: That is right.

COMMISSIONER McCUTCHEON: You might just, and I wouldn't blame you if you did, not have the discount house as a member 'pharmacist.'

MR. WILKINSON: No comment.

THE CHAIRMAN: Thank you very much, gentlemen. You can understand from what I said before we value your contribution very highly indeed.

MR. WILKINSON: Thank you very much, sir.







THE SECRETARY: Mr. Chairman, we will now have the Canadian Library Association, Special Committee on Medical Science Libraries. It will be Exhibit 260. Reverend Father Paul Drouin will make the presentation and introduce the persons with him. He will not read the summary and recommendations but will read a short statement he has prepared.

--- EXHIBIT NO. 260: Submission of the Canadian Library Association, Special Committee on Medical Science Libraries.

SUBMISSION OF THE CANADIAN LIBRARY ASSOCIATION,  
SPECIAL COMMITTEE ON MEDICAL SCIENCE LIBRARIES.

Appearances: Rev. Father Paul Drouin  
Miss Grace Hamlyn  
Mr. R. Blackburn





MR/hm

Drouin

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4 Mr. Chairman and members of the  
5 Commission: It is my pleasure to introduce the delega-  
6 tion on whose knowledge and experience I shall call,  
7 with your permission, to give the best possible answers  
8 to any explanations you may desire in connection with  
9 this brief. Miss Grace Hamlyn, medical librarian at  
10 McGill University and Chairman of the Committee on  
11 Medical Science Libraries and Mr. Robert Blackburn,  
12 chief librarian at the University of Toronto.

13 Mr. Chairman, since the summary and  
14 recommendations of the brief we present are very short,  
15 with your permission I will read a statement covering  
16 the identification of our Association and the main points  
17 and recommendations of the brief.

18 THE CHAIRMAN: We invite you to take  
19 a chair if you like.

20 REV. FATHER DROUIN: If you please ---

21 THE CHAIRMAN: If you are used to the  
22 pulpit.

23 REV. FATHER DROUIN: I feel better,  
24 my ego feels better when I stand, for obvious reasons.

25 Before I read this brief summary I would  
26 like to make two changes in the text of the brief.

27 The first one on page 4, the last complete line of the  
28 first paragraph should read: "Report of the Medical  
29 Education Project". The word "project" has been omitted,  
30 of the Royal Commission.

Then the second one on page 6, paragraph  
9, instead of "enrolled in professional and Ph.D.  
studies" the text should read "enrolled in advanced







professional and Ph.D. studies."

The Officers and Members of the Canadian Library Association wish to express their appreciation of the courtesy of the Royal Commission on Health Services in accepting a brief prepared by the Association's Special Committee on Medical Science Libraries.

The Canadian Library Association, a private corporation organized under Part 2 of the Companies Act of Canada without share capital, has as its purpose:

- (a) To promote education science and culture within the nation through library service;
- (b) To promote high standards of librarianship and the welfare of librarians;
- (c) To co-operate with library associations both within and outside of Canada and with other organizations interested in the promotion of education, science and culture.

Its membership of 2107 includes members from every province of Canada and the Northwest Territories. The Association is financially supported by its membership fees, by grants-in-aid from the ten provinces and by grants to underwrite particular projects. It maintains an Executive Office in Ottawa. The bulk of its work is done by voluntary committees of which it has more than 60, and by 9 sections. The Association is governed by a Board of Directors and a





Drouin

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Council. The members of this Commission will be relieved to learn at this point that the Association as such is not asking for money but is concerned about the improvement of medical library services.

Its Special Committee on Medical Science Libraries which presents this brief is of very recent foundation; it was officially constituted on the 9th of February 1962, at the first meeting of all Canadian medical school libraries held in Ottawa which had been approved by the Association of Canadian Medical Colleges and financed by the Deans of our medical schools.

The reasons behind this meeting are the same which have prompted its members to present their case before the Royal Commission. They may be expressed, in one sentence: The uneasy realization that our medical library services are becoming more and more inadequate to meet the increasing demands of continuing medical education and medical research. This inadequacy is described in paragraphs 3, 4 and 5 of the brief, in rather boldly affirmative statements which reflect a conviction acquired by actual dealings with library patrons rather than substantiated by statistics which the Committee is still unable to provide in full. A more objective knowledge of the actual situation should be gathered from the official survey which the Committee has requested at its first meeting and which will be launched here in Toronto tomorrow.

Paragraph 6 of the brief brings forward a fact which by itself could justify our presence before







Drouin

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4 the Royal Commission. This fact is the absence of a  
5 specifically medical bibliographic centre that could  
6 unify the services of scattered Canadian medical collections  
7 and co-ordinate their growth in a more normal way for  
8 the benefit of Canadian medical research as a whole.  
9 Effective co-operation cannot be attained without such  
10 a centralized agency.

11 The Committee therefore recommends  
12 first the establishment of a national medical  
13 bibliographic centre.

14 And because of the growing inadequacy  
15 of medical libraries to meet the challenge of continuing  
16 medical education and increasing medical research, the  
17 Committee also recommends that financial support be  
18 granted. In this respect, the Committee is aware that  
19 such financial support will have to come through proper  
20 channels, that is, through the institutions responsible  
21 for medical education and research. It therefore suggests  
22 that grants to universities and other institutions  
23 be increased in such wise that a portion of them be  
24 destined for library purposes.

25 There is a definite relation between  
26 medical care, medical education, medical research, and  
27 medical library services. In presenting this brief, the  
28 Committee on Medical Science Libraries feels that it  
29 serves the interest of Canadian Health Services.

30 THE CHAIRMAN: What is the situation  
in Canada today? The scholar doing post-graduate  
studies has need for some work or treatise of some kind.  
Where does such a scholar get his foundation material?





Drouin

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4 REV. FATHER DROUIN: Well, of course,  
5 he will get it from our libraries, mostly. As we say  
6 in the brief, mostly medical school libraries because  
7 in Canada, except for two outstanding examples, medical  
8 literature is in the medical school libraries. The  
9 exception, of course, will be the Academy of Medicine,  
10 Toronto, and the Department of National Health and  
11 Welfare which has a good library of its own so if we  
12 had the material, it will be found usually in these  
libraries.

13 We point out in the brief that too  
14 often now we have to go outside of Canada, mostly to  
15 the National Library of Medicine in Washington and if  
16 we do not have to go outside of Canada, too often, as  
17 we point out we have to go to two main libraries actually  
18 existing in Canada and they are McGill and Toronto and  
19 we think that the situation is not as good as it should  
be.

20 THE CHAIRMAN: Does that restrict the  
21 opportunity of scholars elsewhere than at Toronto and  
Montreal?

22 REV. FATHER DROUIN: Specifically  
23 speaking it shouldn't because McGill and Toronto are  
24 always willing to loan us their books, but I am speaking  
25 maybe just for myself. I have noticed quite often when  
26 you don't have in your library something which is  
27 readily available, they will tell you well forget about  
28 it. I mean if you have to get it from elsewhere, and  
29 especially from outside of the country, very often they  
30 will say well don't take this trouble, and I think it is







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4 not good.

5 If we tell them, after reading a union  
6 list that I can get this from Toronto, maybe even from  
7 Alberta; well that is fine but if we have to go to  
8 Washington, according to my own experience, quite often  
9 they will say that is too far, though it might be nearer  
10 than getting a book from British Columbia but I mean  
11 it's outside the country, and I think it doesn't help.

12 MISS HAMLYN: May I say, Mr. Chairman,  
13 that we have requests from scholars at distances from  
14 these major centres where a vast inter-library loan  
15 arrangement has been going on for many years, but that  
16 is becoming difficult because there are so many  
17 research centres developing throughout the country.  
18 Therefore, we are finding that one library cannot supply  
19 the needs of the whole country very easily.

20 We have not as yet adequate photo-  
21 copying arrangements, but it is our hope that very soon  
22 that may be corrected and that we may have major centres  
23 having expert and expensive photo-copying arrangements  
24 because the little machines will not reproduce satisfactory  
25 medical illustrations in the medical journals.

26 What we believe, as we mention, is  
27 that there is too great a reliance on the older established  
28 libraries and there should be, perhaps, for research  
29 purpose the build-up of collections in the other  
30 universities of the country beyond the central area, and  
we feel that perhaps the business of library service  
has departed or gone beyond being a matter of individual  
institutions, and we would like to suggest, therefore,





Drouin

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4 that it be on a coast to coast basis, and therefore  
5 you could build up collections in a co-operative way  
6 because we are finding that with the increase in grants,  
7 and they are vastly increasing, none of these comes  
8 to the library part of the operation and hence the  
9 demands upon us, it's very difficult for us to meet  
either in or out of the country.

10 THE CHAIRMAN: Is that the way you  
11 see it in Toronto too?

12 MR. BLACKBURN: Yes sir. Very much  
13 so. I think I would like to qualify one statement that  
14 Father Drouin made. He said McGill and Toronto were  
15 always, I don't think he said eager, but glad to lend  
material.

16 I cannot speak for McGill but at  
17 Toronto we have been increasingly reluctant because  
18 with the increase of research on our own doorstep, we  
19 simply cannot afford to send out, without restriction,  
20 journals which may be wanted here tomorrow and for  
21 this reason our official policy is that while we do not  
22 actually refuse, we certainly encourage people to use  
23 our photo-copying facilities which until now have been  
24 rather expensive and not very satisfactory for this  
kind of material.

25 We certainly need greater collections  
26 for our own research here, but we would also be interested  
in the development of other research centres.

27 COMMISSIONER FIRESTONE: I would like  
28 to express, first of all, my pleasure in seeing on  
29 your delegation Miss Grace Hamlyn, a librarian from  
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that it be on a coast to coast basis, and therefore  
you could build up collect one in a cooperative way  
because we are finding that with the area is small  
and they are vastly increasing, none of these comes  
to the library part of the collection and none the  
remains upon us, it's very difficult to get to reach  
either in or out of the library  
The chairman is that the way you

see it in Toronto fact  
Mr. BLACKBURN: Yes sir. Very good.  
I think I would like to clarify the statement that  
rather than make, we said McGill and I think we were  
always, I don't think he said easier, but I don't think

I cannot speak for McGill and St  
Toronto we have been interested in relationship be made  
with the interest of research on our own country, we  
simply cannot afford to send out, without restriction  
journals which may be wanted here tomorrow and for  
this reason our official policy is that while we do  
actually receive, we certainly encourage people to use  
our photo-copying facilities which until now have been  
rather expensive and not very satisfactory for this  
kind of material.

We certainly need further collection  
for our own research here, but we would also be interested  
in the development of other research and we  
would like to see it. I would like to see it  
to express, I am of the view that we should be  
your reference. We have a lot of it in the



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4 McGill. I used to get a lot of help from libraries in  
5 McGill many years back. I am glad to see we continue  
6 to get that help in the assignment that is before us.  
7 I have two or three specific questions Father Drouin  
8 and I might address them to you and perhaps you can  
9 pass them on to your colleagues if you so desire. My  
10 first question relates to your recommendation 1, page  
11 1, where you say and I quote:

12 "That a National Medical Bibliographic  
13 "Centre be established in the near  
14 "future."

15 Who will be responsible for such a centre?

16 REV. FATHER DROUIN: This is a very  
17 hard question, of course. We did not want to be too  
18 specific about the details of those things. There are  
19 many possibilities. It won't surely be this Committee;  
20 we are pointing out the possibility of such a centre,  
21 it could be attached to either an existing library or  
22 could be something well absolutely new. Under which  
23 Department of the Government, because it would probably  
24 be under a Department of the Government, I don't know.

25 In England they have a similar  
26 situation and they have three proposals. One was to  
27 establish a completely independent and new centre of  
28 that kind, or to attach it to an existing bibliographic  
29 library and they mentioned mostly the Royal College of  
30 Medicine, or attach it to a kind of centre that they  
have established for scientific research. So we have  
something similar, in a sense. I mean from the point  
of view of a centre of research we have the National





Drouin

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Research Council, which is, for all purposes, a kind of national library of sciences and after all, well, medicine is a science of some kind at least. It could be attached to the National Library when it will be completed or it could be something absolutely new.

COMMISSIONER FIRESTONE: If the National Library is established; and work is underway to achieve this objective, could you visualize such a National medical centre to be a part, an independent part, or independently operating part but within the overall framework of the National Library of Canada?

REV. FATHER DROUIN: Surely, because it is already started up to a certain point because as you know the National Library has all the holdings of main, important libraries in Canada from the point of view of bibliographies and as we point out somewhere in the brief, those holdings are not specifically medical. I mean we don't know what we have exactly in each field of medicine.

For example, the only approach is the author approach. If you know the author you can write the National Library and they will tell you this book is in McGill or Toronto, or something like this but they would be unable to tell us that in Canada ophthalmology is very weak, we do not have many books on ophthalmology.







Drouin

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On the other hand, the National Research Council is in charge of scientific serials including medical serials and journals and so on and they have published their list which is very useful. However, again the same applies there; we do not know exactly what we have in terms of medical journals all over Canada. We know which library has this journal, we do not know how many libraries will have it unless we made a kind of computation because nobody knows about these things, how it can happen.

As I point out somewhere in the Appendix we have discovered that not less than 3,000 journals are not in Canada. Nobody knew about this, it was only by the Union catalogue of the National Research Council we found this. A centre could very well help us to see what exactly we have, what our weaknesses are and what our strengths are if we have any strength anywhere and so on. It could help us in this co-operation between ourselves so that our service will be a kind of national service without having a national library of medicine or something like this. Whether it would be practical, a national library of medicine or a National Research Council or something absolutely independent, this would have to be studied much more.

As we suggest in the beginning of our recommendations we recommend that further studies be subsidized which will lead to the establishment of a bibliographic centre.

COMMISSIONER FIRESTONE: And this centre, will it really more than just maintain an index;





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Drouin

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it will do analysis of pharmaceuticals pointing out the strength and weakness of the situation and perhaps go forward with suggestions on how this could be improved? Is that what you visualize?

REV. FATHER DROUIN: I think so. We visualize a kind of co-operation because up to now we have been going, each of us, in our own institution doing the best work possible with the money we have. There is certainly a great deal of duplication that, perhaps, should not exist and unless we can have a better coverage of the whole literature then we will have existence of this duplication and no one to point it out. The bibliographic centre would do that.

COMMISSIONER FIRESTONE: To achieve this objective would you say may need more than a centre, you would need an advisory committee comprising the major librarians across Canada so the findings made can be implemented, at least, certain decisions made to use resources more efficiently?

REV. FATHER DROUIN: Of course, the Committee of the Canadian Library Association will be ready to co-operate with such a centre in any way. It is really two ways, as an Association and as a Committee of this Association but it does not belong to us to set up that centre.

COMMISSIONER FIRESTONE: Is it the Canadian Library Association or is the Association of Specialist Libraries?

REV. FATHER DROUIN: It is the Committee of the Association and the Association, as I have read





it will to establish a permanent record of the  
the strength and weakness of the situation and to  
no longer with the situation on how this will be  
improved? Is that what you want?  
Yes, that is what I want. I want to  
visualize a kind of co-operation between us to how we  
are being, each on his own initiative.  
During the past few years with the money we have  
there is certainly a great deal of effort being put  
perhaps, should not exist and what we can have a  
series of reports of the whole literature that we will  
have existence of the situation and no one to point  
it out. The anthropological society would be that.  
Completely different. I am not  
this objective would you say any more than  
being, you would need an advisory committee  
the major libraries a series of books as the first  
can be suggested, at least, certain conditions must  
are reasonable and efficient?  
Committee of the Canadian Library Association will be  
ready to co-operate with such a committee in any way. It  
is really two ways, as an association and as a body  
of this association and it has been doing so for  
up to the present.  
I am not sure, but I think  
Canadian Library Association is the best body  
to handle this.  
Yes, I think so. It is the best  
to handle this and to the best of my knowledge, but I have been



Drouin

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4 in the submission, there are six sections and a great  
5 number of Committees and before - maybe Mr. Blackburn  
6 would know much more about this than I but first you  
7 start with a Committee and if you hold on and build up  
8 and up and are useful for a while you might become a  
9 section of the Association. We are just beginning, we  
10 are still just a Committee which might increase to  
11 cover hospital libraries and nursing school libraries  
12 and all people interested in that field of medicine  
13 because it covers everything, not only schools but every  
14 medical library in Canada who is concerned about health  
15 services and serves health services.

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17 MISS HAMLYN: I would like to add that  
18 as well as Committees of Libraries, bodies like the  
19 Canadian Medical Association and the Royal College of  
20 Physicians and Surgeons and the Medical Research Council  
21 and all of those in the Association, the Canadian medical  
22 colleges are all extremely interested and concerned with  
23 the library development.

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25 We just wish to emphasize that library  
26 services and collections are an important arm of teaching  
27 and research programs anywhere and since the Government  
28 is very interested in making research grants to a great  
29 extent we wish to draw attention to the fact that  
30 libraries are endeavouring to provide background informa-  
tion and without, as we feel at the moment, perhaps  
recognition of their needs so we are taking this oppor-  
tunity to express it.

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29 COMMISSIONER FIRESTONE: Your point is  
30 well taken that the interest in the subject is much





Drouin

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broader than the interest of librarians themselves.

This brings me to the question I asked Dr. Drouin earlier: is the creation of the bibliographic centre for medical literature sufficient or do you need an advisory committee which will comprise all the groups that Miss Hamlyn was talking about?

REV. FATHER DROUIN: I think so, yes.

MR. BLACKBURN: I think this is partly answered quite indirectly on page 6, where we recommend, first, establishment of the National Medical Bibliographic Centre and also a co-ordination of the country's medical collections into a national service. What we had in mind here is the centre by itself could not do the job but it had to work through existing collections and through all the people concerned in order to get a national service.

COMMISSIONER FIRESTONE: I am very glad that you now have elaborated what you mean by paragraph 3 on page 6. I take it from your answer, Father Drouin, and that of your colleagues, that you would be in favour of not only the creation of a National Medical Bibliographic Centre but also an advisory committee to guide the development of such a centre with such committee representing the professions and other groups as Miss Hamlyn suggested?

REV. FATHER DROUIN: This centre, we do not want it to be only one or two or three libraries as such, it will have to have backing of some other organizations and mostly, of course, medical organizations like the Association of Canadian Medical Colleges and







Drouin

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others concerned with this, which could advise precisely because they will be the ones who will probably pay for it together with the Government. They surely would be asked to be among those participating in this centre as advisory members?

COMMISSIONER FIRESTONE: Thank you for the clarification. May I now come to your second recommendation on page 1, in which you suggest a percentage of all medical research grants from federal agencies be made available to libraries in order to alleviate the strain imposed by research programs. Have you a specific percentage in mind?

REV. FATHER DROUIN: Well now, our specialist in grants would be Mr. Blackburn.

MR. BLACKBURN: Mr. Chairman, I do not think that we have, at the moment, the information that could possibly enable us to give any specific answer to this question. The information that we have is very sketchy and informally gathered from what is given on page 8 in Appendix 2 and from what we can guess about the blanks it would seem that Canadian medical schools are now spending somewhere between \$400,000 and \$500,000 a year in operating their libraries.

My experience suggests that perhaps 25% or at least somewhere between 20% and 30% of this amount would be spent on books and journals. Now, of the grant amounts, which run somewhere in the vicinity of \$10,000,000 a year, something like that, at the moment a percentage of a very small percentage, 2%, would amount to perhaps an additional 50% of what is now being





Blackburn

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spent on medical library services and it could make a very, very large difference to the facilities available.

Now, whether this should be spent all in the individual institutions where research is going on or whether part of that should be used to support a co-operative service, I do not know. We have not worked out these details and we are very fortunate that a study is about to begin which I think will be available to your education project before their report is made. It is possible that this study will bring forth some recommendations that can be considered by your Commission.

COMMISSIONER FIRESTONE: Would this study be concerned, among other things, with the amount that you would feel the Federal Government should grant as an initial research grant for the purpose you envisage in paragraph 2?







/LL/ss

Blackburn 9616

MR. BLACKBURN: I believe the present study is principally a survey of existing facilities, and it would only be by implication that your question could be answered.

COMMISSIONER FIRESTONE: Do I then understand from what you said earlier that you would visualize something like an initial grant of \$200,000.00 to help us to achieve the objective which you have stated in Paragraph 2. I was studying your calculations. Is my arithmetic correct?

MR. BLACKBURN: Yes, sir. As a Committee we haven't really been able to work this out, but it is obvious, I think, such a grant initially could certainly make a very large difference, and if they were available then we could see as we went along what was needed from thereon.

COMMISSIONER FIRESTONE: Did you want to add something, Miss Hamlyn?

MISS HAMLYN: I was going to say the survey we are embarking on, that has been embarked on is a study of existing library facilities in Canada. That recognizes the improvement, so therefore I think what you are saying might very well come into that part. I think the amounts that we are speaking of we could use immediately in our existing program with the bibliographic centre, which would increase the resources we have. I think as Mr. Blackburn said, we don't know just what would be involved.

COMMISSIONER FIRESTONE: Do I understand the Educational Committee would receive this report





Blackburn 9617

as and when it is available. If there are some financial implications that could be developed out of your survey, it would certainly help our Education Committee and would help this Commission, as you will appreciate, if we are going to make certain recommendations based on your Paragraph 2. What we would like to have is some concrete advice from you as to what you have in mind and how this money would be used.

MR. BLACKBURN: Well, sir, I certainly think we could expect there will be something available to you through your education project.

COMMISSIONER FIRESTONE: Thank you very much.

THE CHAIRMAN: Dr. Strachan? Fr  
Baltzan?

COMMISSIONER BALTZAN: Yes, Mr. Chairman. Would you tell us do your members, the Medical College librarians plus the others you have mentioned, do they also as serve medical librarians in hospitals?

FATHER DROUIN: Yes, very often. Very often because it is a question which hasn't been studied deeply, at least, by anybody, but I think many of our hospitals outside of our university hospitals have very poor facilities. There are many who will call very frequently on the medical school libraries to supply material for the doctors who might need them in the clinical fields and in research.

COMMISSIONER BALTZAN: Is there a place for them also in the Medical Records Office of the hospitals?







Hamlyn 9618

MISS HAMLYN: I think the Medical Record Offices in the hospitals are quite separate from the medical libraries. I think in answer to that question, I think the medical school libraries or the librarians of the medical faculties of the universities along with the Toronto Academy of Medicine are serving the library needs of the nation. It is under this weight we are bowing. There are librarians in the hospitals, but the hospitals are all closely in touch, I think, with the medical library facilities of the university, the closest one, in order to fulfill their research needs and their research programs are growing so that we are in touch with hospitals, with individual doctors in far-off places unable to get books and journals, and our own teaching hospitals, and then we pass things back and forth between us all. It is a vast program so that the medical library services of the country at this moment, I would say, are based in the libraries of the medical faculties.

COMMISSIONER BALTZAN: I am thinking of the future needs and future growth and future requirements, these areas who might call upon people who are prepared as you are preparing your membership.

MISS HAMLYN: Yes, that is very true.

COMMISSIONER BALTZAN: Would you tell us about the twelve schools listed here? Is this where the librarians obtain their training as medical librarians?

MISS HAMLYN: Medical librarians are trained at library schools in the country, taking special training, many of them, in medical librarianship. There





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is no place in Canada for them to get this advanced training. There are six or seven universities in the United States who do this. One of the recommendations that we hope our survey will uncover, as well, is something about the training of medical librarians, which is not possible, as I say, in this country as yet, so that most of the medical librarians in Canada at the moment are trained librarians or specialists in their specialty having had nursing training, medical training or worked in hospitals.

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COMMISSIONER BALTZAN: So that our original librarians, I am asking this for my own understanding --- it says in this pamphlet which I show you, the medical record librarian is a highly specialized person whose training is obtained through a formal one-year course at one of the twelve schools listed below.

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MISS HAMLYN: They are another group, the medical record librarians. They look after, I believe, the case records in the individual hospitals, indexing them accordingly and are specially trained for this purpose. The medical librarians of hospitals look after collections for the doctors and nurses in their research work and activities in the hospital. They do work with the medical record librarians, but they are not the same.

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COMMISSIONER BALTZAN: You will have to excuse my partiality in putting this question.

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THE CHAIRMAN: Father Drouin, Miss Hamlyn, Mr. Blackburn, we are very grateful to you for producing this new facet to the problem of medical education







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4 and post-graduate education. For the moment I think we  
5 are going to be quite happy if you pass it along to Dr.  
6 MacFarlane and his research project. I am sure it will be  
7 in the best of hands possible so far as we are concerned.  
8 It will come back to us then with the benefit of their  
9 research and advice on it. We thank you.

10 We will adjourn until 9:30 tomorrow  
11 morning.

12 ----Whereupon the hearing adjourned.  
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